



Covered California
Qualified Health Plan
New Entrant
Certification Application for Plan
Year 2016

January 15, 2015

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Information submitted in response to this application by the applicant will be held in confidence pursuant to Government Code Section 100508 or 6254(k) under the official information privilege, as applicable, unless the information submitted has already been made public. Throughout this application, any reference to the "Exchange" refers to the California Health Benefit Exchange, also known as Covered California.

1. GENERAL INFORMATION AND BACKGROUND

1.1 ATTESTATION

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

Issuer Name

NAIC Company Code

NAIC Group Code

Regulator(s)

Federal Employer ID

HIOS/Issuer ID

Corporate Office Address

City

State

ZIP

Primary Contact Name

Contact Title

Contact Phone Number

Contact E-mail

Check applicable categories: Individual SHOP

New Entrant Categories for Individual Market: Check applicable box:

1. Medi-Cal Managed Care Plan Individual

2. Received Knox-Keene plan approval or certificate of authority to sell health insurance since August 2012 Individual

3. Other Health Issuer proposing to serve Covered California enrollees in zip codes identified in Appendix B Individual

On behalf of the Applicant stated above, I hereby attest that I meet the requirements in this New Entrant Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and if Applicant is selected to offer Qualified Health Plans (QHPs), may decertify those QHPs should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this New Entrant Application.

Date: _____
Signature: _____
Printed Name: _____
Title: _____

1.2 PURPOSE: The California Health Benefit Exchange (Exchange) is accepting applications from eligible Health Insurance Issuers¹ (Applicants) to submit proposals to offer, market, and sell qualified health plans (QHP) through the Exchange beginning in 2015, for coverage effective January 1, 2016. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted applications and reserves the right to select or reject any Applicant or to cancel the Application at any time.

Issuers who have responded to the Notice of Intent to Apply will be issued a web login for on-line access to the final application, and instructions for use of the login for the QHP New Entrant Application.

1.3 BACKGROUND: Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Effective January 1, 2014, the California Health Benefit Exchange offers a statewide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market. Although the focus of the Exchange is on individuals and small businesses who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with fewer than 50 employees.

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

- **Consumer-Focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.

¹ The term "Health Issuer" used in this document refers to both health plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing health coverage, while the term "Qualified Health Plan" refers to a specific policy or plan to be sold to a consumer. Qualified Health Plans are also referred to as "products". The term "Applicant" refers to a Health Insurance Issuer who is seeking a Qualified Health Plan contract with the Exchange.

- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

The Exchange needs to address these issues for the millions of Californians who enroll through it to get coverage, but it is also part of broader efforts to improve care, improve health, and control health care costs.

California has many of the infrastructure elements that allow the Exchange to work with health plans, clinicians, hospitals, consumer groups, purchasers and others as partners to support the changes needed to achieve the triple aim of better care, better health, and lower cost. These infrastructure elements include the state's history of multispecialty and organized medical groups, the presence of statewide and regional managed care health maintenance and preferred provider organizations, the public reporting of health care information and delivery system performance, and the active efforts by public and private sector payers to test new and innovative models of care delivery and payment reform.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small

group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans that will be offered in the Exchange.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively ... contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health issuers.²

These concepts, and the inherent trade-offs among the California Health Benefit Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered on the Individual and the SHOP Exchanges.

This application has been designed consistent with the policies and strategies of the California Health Benefit Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

Important issues include how much to standardize the individual and small group market rating rules how much to standardize the benefits and member cost-sharing for the Exchange plans, how many and what type of products are offered, what reporting and quality standards the plans must meet, and how to build upon and encourage innovation in both health care delivery and payment mechanisms.

1.4 APPLICATION EVALUATION AND SELECTION

The evaluation of QHP New Entrant Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the Exchange's goals. The Exchange wants to provide an appropriate range of high quality plans to participants at the best available price. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans in August 2012 which are considered in the review of QHP proposals. These guidelines are:

Promote affordability for the consumer and small employer – both in terms of premium and at point of care

The Exchange seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers in terms of premiums and at the point of care while fostering competition and stable premiums. The Exchange will seek to offer health plans, plan designs and provider networks that will attract maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

Encourage "Value" Competition Based upon Quality, Service, and Price

² California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).

While premium and out-of-pocket costs for consumers will be a key consideration, contracts will be awarded based on the determination of "best value" to the Exchange and its participants. The evaluation of Issuer QHP proposals will focus on quality and service components, including past history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population. This commitment to serve the Exchange population is evidenced through general cooperation with the Exchange's operations, provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2016 plan year.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard and Non-Standard Benefit Plan Designs³

The Exchange is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. QHP Applicants are required to adhere to the Exchange's standard benefit plan designs (either copay or coinsurance plan) in each region for which they submit a proposal. In addition, QHP Applicants may offer the Exchange's standard Health Savings Account-eligible (HSA) design, and QHP SHOP Applicants may propose an alternate benefit design. Applicants may choose to offer either or both of the Gold and Platinum standard benefit plan designs. To the extent possible, both HMO and PPO products will be offered. If there are meaningful differences in network design, levels of integration, and other innovative delivery system features, multiple HMO or PPO products will be considered for the same geographic service area. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping PPO networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

The Exchange must be statewide. Issuers are encouraged to submit QHP proposals in all geographic service areas in which they are licensed, and preference will be given to Issuers that develop QHP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population

³ The 2016 Standard Benefit Designs will be finalized when the 2016 federal actuarial value calculator is finalized.

Performing effective outreach, enrollment and retention of the low income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange is central to the Exchange's mission. Responses that demonstrate an ongoing commitment to the low income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations beyond the minimum requirements adopted by the Exchange will receive additional consideration. Examples of demonstrated commitment include: having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution that is reasonably distributed, having contracts with Federally Qualified Health Centers, and supporting or investing in providers and networks that have historically served these populations in order to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness and reducing costs. The Exchange wants QHP offerings that incorporate innovations in delivery system improvement, prevention and wellness and/or payment reform that will help foster these broad goals. These may include various models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention or efforts to increase reporting transparency in order to provide relevant health care comparisons and to increase member engagement in decisions about their course of care. QHP proposals that incorporate innovative models, particularly those with demonstrated effectiveness and a track record of success, will be preferred.

Encourage Long Term Partnerships with Health issuers

A goal of the Exchange is to reward early participation with contract features that offer a potential for market share and program stability. Applicants are encouraged to submit competitive rates. The Exchange will take steps to foster rate and plan stability and encourage QHP investments in product design, network development, and quality improvement programs. Application responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission are strongly encouraged, particularly those that include underserved service areas and those that leverage Issuer efforts to provide better care, improve health, and lower cost.

1.5 AVAILABILITY

The QHP Applicant must be available immediately upon contingent certification as a QHP to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2016. Successful Applicants will

also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS) and any other eligibility and enrollment system used by the Exchange, including the system operated by Pinnacle HCMS (for SHOP plans only). The Exchange expects to negotiate and sign contracts prior to September 1, 2015. The successful Applicants must be ready and able to accept enrollment as of October 1, 2015.

1.6 APPLICATION PROCESS

The application process shall consist of the following steps:

- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates; and
- Execution of contracts with the selected New Entrant QHP Issuers.

1.7 INTENTION TO SUBMIT A RESPONSE

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

The Applicant's letter of intent must identify the contact person for the application process, along with contact information that includes an email address, a telephone number, and a fax number. On receipt of the non-binding letter of intent, Covered California will issue instructions and login and password information to gain access to the online portion(s) of the Application.

An Issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Applicant information is not expected to be released until selected Issuers and QHP proposals are announced in July 2015. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

The Exchange will correspond with only one (1) contact person per Applicant. It shall be the Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. The Exchange shall not be responsible for application correspondence not received by the Applicant if the Applicant fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

Application Contact:

Taylor Priestley

Taylor.Priestley@covered.ca.gov

(916) 228-8397

1.8 KEY ACTION DATES

Action	Date/Time
Approval of Final Application	January 15, 2015
New Entrant Letters of Intent due to Covered California	February 16, 2015
Completed New Entrant Applications Due (include 2016 Proposed Rates & Networks)	May 1, 2015
Negotiations between New Entrant Applicants and Covered California	June 2015
Final QHP Recertification/Decertification/New Entrant Certification Decisions	August 2015
New Entrant QHP Contract Execution	September 2015

2. LICENSED AND IN GOOD STANDING

2.1 In addition to holding all of the proper and required licenses⁴ to operate as a health issuer as defined herein, the Applicant must indicate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the Applicant has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years (See Appendix A Definition of Good Standing). Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for the purpose of determining Good Standing.

Applicant must check the appropriate box. If Applicant selects no, the application will be disqualified from consideration.

- Yes, issuer is in good standing
- No

⁴ The Exchange reserves the right to require licenses to be in place at the time of QHP selection in the case of new applicants for licenses. Applicants who are not yet licensed should indicate anticipated date of licensure.

2.2 Does your organization have any ongoing labor disputes, penalties, fines, or corrective action citations for federal or state workplace safety issues? If yes, indicate whether these will be addressed by the date applications are due.

- Yes (explain)
- No

2.3 Are you seeking any material modification of an existing license from the California Department of Managed Health Care or certificate of authority from the California Department of Insurance for any commercial individual or small group products proposed to be offered through Covered California?

Applicant must check the appropriate box.

- Yes
- No

If yes, Applicant must complete Attachment A (Regulatory Filings) to indicate type of filing and provide additional information. Updates to Attachment A must be made on a continuous basis as Applicant files amended documents related to an initial filing with the regulator.

2.4 Separate from the Applicant's response to this application, Applicant must submit all materials to the California regulatory agency necessary to obtain approval of product/plan and rate filings that are to be submitted in response to this application. Applicant must complete Attachment A (Regulatory Filings) to indicate product filings related to proposed QHP products that have been submitted for regulatory review and include documentation of the filings as part of the response to this application. If filings are not complete, the Applicant must update the Exchange with such information as it is submitted for regulatory review.

The California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) have primary responsibility for regulatory review and issuing preliminary recommendations to the Exchange of certain selection criteria listed below in the definition of good standing in addition to applying the minimum licensure requirements. All licensure, regulatory and product filing requirements of DMHC and CDI shall apply to QHPs offered through the Exchange. Issuers must adhere to California insurance laws and regulations including, but not limited to, those identified in the roster of Good Standing elements that follow. Applicants must respond to questions raised by the agencies in their review. The agencies will conduct the review of the components outlined in Appendix A (Definition of Good Standing).

2.5 Applicant must confirm it will agree to immediately submit to the Exchange the results of final financial, market conduct, or special audits/reviews performed by the Department of Managed Health Care, California Department of Social Services, Department of Covered Services, US Department of Health and Human Services,

and/or any other regulatory entity within the State of California that has jurisdiction where Contracted QHP serves enrollees.

Yes

No

3. APPLICANT HEALTH PLAN PROPOSAL

Applicant must submit a health plan proposal in accordance with submission requirements outlined in this section. Applicant's proposal will be required to include at least one of the standard plan designs and use the same provider network for each type of standard plan design in a family of plans or insurance policies for specified metal level actuarial values.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Tiered networks are not permitted. Applicants must agree to adhere to the Exchange's standard benefit plan designs without deviation.

Plan or Policy Submission Requirements

QHP Applicant must submit one of the 2016 Standard Benefit Plan Designs and offer all four metal levels and a catastrophic plan in its proposed rating regions.

QHP Applicant may submit proposals for both standard benefit plan designs and the Health Savings Account-eligible standard design. Health Savings Account-eligible plans may only be proposed at the bronze level in the individual exchange, and only at the bronze and silver levels in the SHOP.

In addition to the standard benefit design, SHOP Applicants may submit proposals for an alternate benefit design.

3.1 QHP New Entrant Applicant must comply with 2016 Standard Benefit Plans Designs. Applicant must certify its proposal includes a health product offered at all four metal tiers (bronze, silver, gold and platinum) and catastrophic for each individual plan it proposes to offer in a rating region. SHOP New Entrant Applicants must certify proposals include a health product offered at all four metal tiers (bronze, silver, gold and platinum). If

not, the Applicant's response will be disqualified from consideration. Complete Attachment B1 (Plan Type by Rating Region (Individual)) to indicate the rating regions and number and type of plans for which you are proposing a QHP in the Individual Exchange. If applicable, use Attachment B2 (Plan Type by Rating Region (SHOP)) to submit a SHOP proposal.

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

3.2 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric dental Essential Health Benefit. QHP issuer must indicate that it will adhere to the 2016 standard plan design which includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

3.2.1 Individual Exchange QHPs proposed for 2016 include all ten Essential Health Benefits.

- Yes
- No

3.2.2 SHOP Exchange QHPs, if applicable, proposed for 2016 include all ten Essential Health Benefits.

- Yes
- No

3.3 If Applicant answered yes to 3.2.1 or 3.2.2, Applicant must describe how it intends to embed the pediatric dental Essential Health Benefit as described in 3.2. Describe any intended subcontractor relationship, if applicable, to offer the pediatric dental Essential Health Benefit. Include a description of how QHP issuer will ensure that the subcontractor adheres to contractual pediatric dental quality measures as determined by Covered California.

3.4 QHP issuer must submit copies of draft disclosure documents including Evidence of Coverage, Summary of Benefits and Coverage and any member disclosure documents that describe proposed 2016 QHP benefits. These draft documents are to be submitted with the response to this application, prior to or contemporaneous to filing with the applicable regulator.

3.5 QHPs are required to offer products in accordance with Covered California's Standard Benefit Plan Designs, which stipulate four tiers of drug coverage: 1) Generic, 2) Preferred Brand Drugs, 3) Non-preferred Brand Drugs, 4) Specialty Drugs. Medications are a point of great concern for

consumers. Applicants are urged to make drug tiering decisions that avoid prohibited discrimination. See 45 CFR 156.125.

3.5.1 Submit a copy of the full tiered formularies, by product, which will be available to Covered California enrollees. Provide the most recent version of your formulary showing the effective date.

3.5.2 If formularies are not already tiered according to the 2016 Standard Benefit Plan Designs, provide additional information identifying which medications will be included in each of the four required tiers.

Identify medications by tiers:

- Generic Drugs
- Preferred Brand Drugs
- Non-preferred Brand Drugs
- Specialty Drugs

3.5.3 Provide definitions for each of the four tiers (e.g.: describe how Applicant defines a “specialty drug”).

3.5.4 Describe the criteria for categorizing drugs into each of the four tiers of drug coverage.

3.6 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the third full year of operation of the Exchange, effective January 1, 2016, or for the SHOP plan year. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies. Premium proposals will be due May 1, 2015. To submit premium proposals for Individual products, QHP applicants must complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT) and the Rates Template located at:

http://www.serff.com/plan_management_data_templates.htm. See Section 9 SHOP Supplemental Application for instructions to submit SHOP Premium Proposals. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange’s request, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology.

Applicant shall provide justification, documentation, and support used to determine rate changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange-specific rate development process. The Exchange may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

3.7 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. To indicate which zip codes are within the licensed geographic service area by type of platform and proposed Exchange product, complete and upload through SERFF the Service Area Template located at http://www.serff.com/plan_management_data_templates.htm.

- Yes, health plan proposal covers entire geographic service area; template completed
- No

3.7.1 For Plan Year 2016, Covered California is encouraging new entrant QHP issuers to expand coverage in geographic areas where there are fewer than three plan choices in 2015. See Appendix B (Geographic Areas with Fewer than Three Plan Choices in 2015) for zip codes identifying these geographic areas.

- Yes, health plan proposal includes zip codes identified in Appendix B.
- No, health plan proposal does not include zip codes identified in Appendix B.

4. PROVIDER NETWORK⁵

All requests for provider related data pertain to networks to be available to Covered California enrollees.

4.1 Use Attachment C1 (2016 Enrollment Projections (Individual)) and Attachment C2 (2016 Enrollment Projections (SHOP)) to submit 2016 enrollment projections by product that Applicant proposes for 2016. Enrollment projections must be consistent with enrollment projections filed with the regulator.

4.2 Describe your network strategy:

⁵ A Health Care Service Plan as defined in Health and Safety Code 1345(f) may use any delivery platform (e.g., HMO, PPO or EPO). The term "plan" is defined as consistent with 45 C.F.R. 144.103.

4.2.1 Does Applicant conduct provider negotiations and manage its own network or does applicant lease a network from another organization? If applicant leases a network, describe the terms for the lease agreement: 1) length of the lease agreement (effective date and termination date), 2) ability to direct the addition of new providers, 3) ability to influence provider contract terms to allow transparency and to implement new programs to enhance care and quality in accordance with the Mission and Vision of Covered California.

4.2.2 Does Applicant allow out of state providers to participate in networks to serve Covered California enrollees? How does Applicant provide access for enrollees who live near the state border and may prefer to access care in the bordering state?

4.3 Describe provider contracting strategy for your projected 2016 network by product or plan (e.g., HMO, PPO or EPO).

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

Applicant's Delivery System Platform	Only Directly Contract with Individual Practitioners (Yes/No)	Only Directly Contract with Risk-Bearing Organizations (Yes/No)	Directly Contract with both Individual Practitioners and Risk-Bearing Organizations (Yes/No)
HMO			
PPO			
EPO			

4.3.2 Will Applicant's off-Exchange mirror product consist of the same provider network that is available for Covered California enrollees?

Yes

No

4.4 Provider network data for both Individual and SHOP Exchange products for 2016 must be included in this submission for all geographic locations to which applicant is applying for certification as a QHP. Submit provider data according to the data file layout Attachment D (Provider Data File Layout). The projected provider network submission for 2016 must be consistent with what will be filed to the appropriate regulator for approval if selected to be a QHP. The Exchange requires the information as requested to allow cross-network comparisons and evaluations.

4.5 Applicant must certify that for each rating region in which it submits a health plan proposal, the proposed products meet the provider network adequacy standards established by the applicable regulatory agency. Provider network adequacy will be evaluated by the governing regulatory agency and confirmed by Covered California. Additionally, for Plan Year 2016, network adequacy standards applicable to dental provider networks will apply to the embedded pediatric dental benefit.

- Yes, health plan proposal meets relevant provider network adequacy standards
- No

Note that the applicable regulatory agency will assess Applicant's compliance with provider network adequacy standards. See Section 5 for Covered California's complete Essential Community Provider (ECP) Network requirements.

4.6 Using the Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications, identify the number and percentage of contracted primary care physicians, specialists and other practitioners that are board-eligible/certified in their respective area of medical specialization in your network for Plan Year 2014. It is expected that over eighty-five percent of network physicians are board-eligible/certified.

4.6.1 Primary Care Physicians (including Family Practice, General Practice, Pediatrics, Internal Medicine and Obstetrics/Gynecology)

Number of Board Eligible/Certified in Contracted Network for 2014: _____

Percent Board Eligible/Certified in Contracted Network for 2014: _____

4.6.2 Specialists (including allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, ophthalmologists, orthopedic surgeons, and otolaryngologists and all other medical specialties)

Number of Board Eligible/Certified in Contracted Network for 2014: _____

Percent Board Eligible/Certified in Contracted Network for 2014: _____

4.7 Identify Centers of Excellence participating facilities that will be available to Covered California enrollees. Specifically indicate the locations of each facility and the type of procedures included, particularly: 1) transplant services (bone marrow, kidney, liver, lung, heart, pancreas), 2) Comprehensive Cancer Care and 3) Perinatal Care.

Type of Procedure	Facility Name and Locations	Available to Covered CA Enrollees? (yes or no)
1) Transplant services (bone marrow, kidney, liver, lung, heart, pancreas),	<i>Name and location if selection in first column</i>	
2) Comprehensive Cancer Care,		
3) Perinatal Care		

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

Applicant must confirm that, if certified as a QHP, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, Applicant shall identify such Participating Provider. Issuer shall, upon renewal of its Provider contract, but in no event later than July 1, 2016, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Applicant agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange.

- Yes, confirmed
- No, not confirmed

Contract Provisions	Description
What is your organization doing to change the provisions of your contracts going forward to make this information accessible?	
List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors	
List provider groups or facilities for which current contract terms preclude provision of information to members	

4.9 Identify network hospitals terminated between January 1, 2014 and December 31, 2014, including any hospitals that had a break in maintaining a continuous contract during this period. Indicate reason for hospital termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

Total Number of Contracted Hospitals: _____

Total Number of Terminated Hospitals between 1/1/2014 – 12/31/2014:

Name of Terminated Hospital	Terminated by Issuer or Hospital	Reason for Termination

4.10 Identify the number of participating providers who have terminated from the provider network between 1/1/2014 – 12/31/2014, by rating region.

Rating Region #	County	Number of Terminated Providers	Number Terminated by Provider	Number Terminated by Issuer

4.11 Identify Independent Practice Associations⁶ (IPA), Medical Groups, clinics or health centers terminated between January 1, 2014 and December 31, 2014, including any IPAs or Medical Groups, Federally Qualified Health Centers or community clinics that had a break in maintaining a continuous contract during this period. Indicate reason for termination: non-agreement on rates, non-compliance with contract provisions, re-design of network or other (explain).

Total Number of Contracted IPA/Medical Groups/Clinics (provide information by region, market or city):

Total Number of Terminated IPA/Medical Groups/Clinics 1/1/2014 – 12/31/2014:

⁶ An independent practice association (or IPA) is an association of independent physicians, or other organization that contracts with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. See also 10 CCR Section 6410 for definition of medical group.

Name of Terminated IPA/Medical Group/Clinic	Region, Market, or City	Terminated by Issuer or Provider	Reason for Termination	Percent of network change/ disruption (# of terminated entities / # total entities)

4.12 Do you perform provider efficiency profiling?

- Yes
- No

If yes, provide sample calculations showing how an individual Provider is ranked relative to its peers for efficiency profiling, and provide a written outline of your appeals and correction process. Please include an explanation of how your provider ranking methodology comports with the Patient Charter, which can be accessed at <http://healthcaredisclosure.org/docs/files/PatientCharter.pdf>.

4.13 What non-financial incentives are used to encourage Members to enhance value by use of lower cost and/or higher quality Providers? Non-financial incentives may include, for example: incentive gifts to encourage completion of Health Assessments, making information available in print or online to members to inform care decisions, encouraging use of providers with high profile scores or encouraging member choice of Centers of Excellence programs or other preferred providers for services. Check all that apply.

- Non-financial incentives not used
- Information on provider quality and/or costs made available to members through employer, health plan, or other sources
- Other (describe)

Is Applicant willing to add a reference to “Choosing Wisely” to its member materials used to support member access to information on shared decision options? Choosing Wisely information can be accessed at www.choosingwisely.org.

- Yes
- No

4.14 For Plan Year 2016, describe your plans for network development by proposed Covered California product or plan. This description of intended network development should be consistent with the network filings that will be or have been filed with the appropriate regulator.

4.14.1 Do you anticipate making significant changes to your current network(s) that could be described as a narrow network (defined as fewer than the issuer's complete set of contracted providers in a given rating region)?

Anticipate making significant changes Yes No

4.14.2 If yes to 4.14.1, describe any plans for narrow networks, by product.

4.14.3 Will Covered California enrollees in Applicant's PPO plans in a given rating region have access to providers in that Applicant's EPO plans at in-network cost-sharing?

Yes

No

If yes, describe of Covered California enrollee access between EPO and PPO networks and indicate the geographic regions that will be affected.

4.14.4 Will Covered California enrollees in Applicant's EPO plans in a given rating region have access to providers in that Applicant's PPO plans at in-network cost sharing?

Yes

No

If yes, describe Covered California enrollee access between PPO and EPO networks and indicate the geographic regions that will be affected.

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

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

4.15 If Applicant is selected as a certified Qualified Health Plan (QHP), applicant must 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. Once certified, QHP 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.

- Yes, Applicant confirms it will make information available to enrollees and acknowledges expectation to make specific cost and quality data available.
- No, not confirmed

4.16 Covered California has a mission to improve health care quality. Many new models of health care delivery are being developed to improve health care quality. Describe applicant's efforts, if any, to structure provider networks to drive improved quality.

4.16.1 Describe efforts to improve care for the following three domains: 1) Access for all enrollees, 2) access for enrollees with chronic conditions and 3) implementation of new models for cost-efficiency.

4.16.2 Will these programs be available for Covered California enrollees as of January 2016?

4.16.3 If you have not implemented any such programs, how might you approach this for the Exchange?

4.16.4 Identify the strategies you have implemented or intend to implement to promote access and care coordination:

- Accountable Care Organizations (ACO)
- Patient-Centered Medical Homes (PCMH)
- The use of a patient-centered, team-based approach to care delivery and member engagement
- A focus on additional primary care recruitment, use of Advanced Practice Clinicians (nurse practitioners, physician assistants, certified nurse midwives) and development of new primary care and specialty clinics
- A focus on expanding primary care access through payment systems and strategies
- The use of intensive outpatient care programs (e.g., "Ambulatory ICU") for enrollees with complex chronic conditions
- 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

- Support of physician and patient engagement in shared decision-making
- Providing patient access to their personal health information
- Promoting team care
- The use of telemedicine
- Promoting the use of remote patient monitoring

4.17 Delivery System Reform: In keeping with its mission, vision and values, the Exchange is charged with encouraging delivery system reforms which increase quality and consumer choice, lower cost and improve care. Complete Attachment E1 (Delivery System Reform (Individual)) by indicating which delivery system reforms your health plan offers now and which it will offer to serve Exchange enrollees in 2016 and in which rating regions. If applicable, complete Attachment E2 (Delivery System Reform (SHOP)).

If your plan does not offer any reforms, describe any plans to develop such programs for the Exchange enrollees.

5. ESSENTIAL COMMUNITY PROVIDERS

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

- i. Qualified Health Plan Applicants must use Attachment F (Essential Community Provider Network Data Submission) to indicate contracts with all providers designated as ECP; and
- ii. Applicants must demonstrate sufficient geographic distribution of a mix of essential community providers reasonably distributed throughout the geographic service area; and
- iii. Applicants must demonstrate contracts with at least 15% of 340B entities (where available) throughout each rating region in the proposed geographic service area; and
- iv. Applicants must include at least one ECP hospital (including but not limited to 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county and children's hospitals) per each county in the proposed geographic service area where available.

Determination that an essential community provider network meets the standard of sufficient geographic distribution with a balance of hospital and non-hospital

providers and serves the low-income population within the proposed geographic service area requires the Applicant to apply interactively all four criteria above. The Exchange will evaluate the application of all four criteria to determine whether the Applicant's essential community provider network has achieved the sufficient geographic distribution and balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of low-income population throughout the county that are not served by a sole contracted ECP hospital.

Federal rules currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QHP's benefit plan. Certified QHPs will be required in their contract with the Exchange to operate in compliance with all federal rules issued pursuant to the Affordable Care Act, including those applicable to essential community providers.

Essential Community Providers include those providers posted in the Covered California Consolidated Essential Community Provider List available at:

<http://hbex.coveredca.com/stakeholders/plan-management/>

The Exchange will calculate the percentage of contracted 340B entities located in each rating region of the proposed geographic service area. All 340B entity service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act (42 U.S.C. 1396r-8);
2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List FY 2013-2014;
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs;
4. Community Clinic or health center licensed as either a "community clinic" or "free clinic", by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code section 1206;
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program; and
6. Federally Qualified Health Centers (FQHCs).

Low-income is defined as a family at or below 200% of Federal Poverty Level. The ECP data supplied by Applicant will allow the Exchange to plot contracted ECPs on

maps to compare contracted providers against the supply of ECPs and the distribution of low-income Covered California enrollees.

If applicant is certified as a QHP, it will be an expectation for certified QHPs' provider contracts entered into on or after January 1, 2016, that certified QHPs shall reference the Centers for Medicare & Medicaid Services Model QHP Addendum for Indian Health Care Providers along with the Overview of the Model QHP Addendum for Indian Health Care Providers attached hereto as Appendix C. Certified QHPs are encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist QHPs in including specified Indian providers in its provider networks.

Alternate standard:

QHP issuers that provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may request to be evaluated under the "alternate standard." The alternate standard requires a QHP issuer to have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted integrated medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

To evaluate an Applicant's request for consideration under the alternate standard, please submit a written description of the following:

1. Percent of services received by Applicant's members which are rendered by Issuer's employed providers or single contracted medical group; and
2. Degree of capitation Issuer holds in its contracts with participating providers. What percent of provider services are at risk under capitation; and
3. How Issuer's network is designed to ensure reasonable and timely access for low-income, medically underserved individuals; and
4. Efforts Issuer will undertake to measure how/if low-income, medically underserved individuals are accessing needed health care services (e.g., maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as CAHPS "getting needed care" survey).

If existing provider capacity does not meet the above criteria, the Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs in order to provide reasonable and timely access for low-income, medically underserved communities.

6. OPERATIONAL READINESS AND CAPACITY & TECHNICAL REQUIREMENTS

6.1 ADMINISTRATIVE AND ACCOUNT MANAGEMENT SUPPORT

6.1.1 Provide a summary of your organization’s capabilities including how long you have been in the business as an Issuer. Do you anticipate making material changes in your corporate structure, such as mergers, acquisitions, new venture capital, management team, location of corporate headquarters or tax domicile, or stock issue? If yes, Applicant must describe.

6.1.2 Provide a description of any company initiatives, either current or planned, over the next 18 – 24 months which will impact the delivery of services to Exchange members during the contract period. Examples include system changes or migrations, call center opening or closing, or network re-contracting.

6.1.3 Do you routinely subcontract any significant portion of your operations or partner with other companies to provide health plan coverage? If yes, identify which operations are performed by subcontractor or partner.

- Yes
- No

6.1.4 Does your organization provide any administrative services that are not performed within the United States? If yes, describe.

- Yes
- No

6.1.5 Applicant must include an organizational chart of key personnel who will be assigned to Covered California. Provide details of the Key Personnel and representatives of the Account Management Team who will be assigned to Covered California.

	Contact Name	Title	Phone (include extension)	Fax	E-mail
President or CEO					
Chief Medical Officer					
Chief Actuary (Lead for Exchange Rate Development)					

Lead Account Manager for Exchange					
Director, Provider Network Management					
Key Contact for CalHEERS technical questions					
Key Contact for Operational Questions					
Other					

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

- Name
- Title
- Department
- Phone
- Fax
- E-mail

6.2 MEMBER SERVICES

6.2.1 QHP will be required to staff sufficiently to meet contractual member services performance goals. Will you modify your customer service center operating hours, staffing requirements, and training criteria to meet Exchange requirements? Check all that apply and describe.

___ Yes: expected operating hours during Open Enrollment are 8 am to 8 pm

___ Yes: staffing requirements - Provide customer service representative ratio to members

___ Yes: training criteria

- Yes: languages spoken
- Yes: interface with CalHEERS and Pinnacle HCMS
- No, the organization can handle the increased volume
- No, not willing to modify operations

6.2.2 How do you provide members information regarding how to use their health insurance? Briefly describe your capabilities.

	Yes/ No	Description
Provider referrals		
Member benefit summaries		
Member EOCs		
Member claims status		
Other		

6.2.3 Do you provide secure online tools for members to understand their out-of-pocket costs and possible costs of clinical care choices? If so, describe.

- Yes
- No

6.2.4 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures.

- Yes, confirmed
- No, not confirmed

6.3 OUT-OF-NETWORK BENEFITS

6.3.1 With respect to non-network, non-emergency claims (hospital and professional), describe the terms and manner in which you administer out-of-network benefits. Can you administer a "Usual, Customary, and Reasonable" (UCR) method utilizing the nonprofit FAIR Health (www.fairhealth.org) database to determine reimbursement amounts? What percentile do you target for non-network UCR? Can you administer different percentiles? What percent of your in-network contract rates does your standard non-network UCR method reflect?

Non-Network Claims	Yes/No	Describe
Ability to administer FAIR Health UCR method		
Targeted UCR percentile		%
Ability to administer different percentiles		
Amount as a percentage of network contract value		%

6.3.2 If selected, Applicant's QHPs will be required to disclose financial information regarding costs of care to Enrollees. If you intend to offer a PPO product which provides coverage for out-of-network, non-emergent care, describe the steps you will take to disclose to Enrollees the amount Issuer will pay for this care and the amount enrollee will be responsible to pay for such care.

6.4 SYSTEMS AND DATA REPORTING MANAGEMENT

Issuers must maintain data interfaces with the Exchange and allow the Exchange to monitor issuer operational performance. The Exchange uses the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) and Pinnacle HCMS for eligibility, enrollment and retention information technology. QHPs must build data interfaces with the CalHEERS and Pinnacle systems and report on transactions.

6.4.1 Technical Interface Capacity

6.4.1.1 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including CalHEERS and any other eligibility and enrollment system used by the Exchange, including the system operated by Pinnacle HCMS, as early as May 2015. Applicant must confirm it will implement systems in order to accept and generate 834, 820, 999 and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information received and transmitted for its intended purpose. Covered California requires QHPs to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

6.4.1.2 Applicant must confirm that it will implement systems in order to accept and generate TA1 and 999 acknowledgement files and other standard format electronic files and utilize the information for its intended purpose. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes.

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

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

6.4.1.4 Applicant must be able to submit provider data in a format as required by Covered California and at intervals requested by Covered California.

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

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

6.4.1.7 Applicant must be able to meet data submission requirements for third party network and clinical analytics vendor, which will require an independent capability for analytics using standard and normalized information sets, standardized risk adjustment, and cross-regional and cross-issuer analysis.

6.4.1.8 Applicant must provide comments on the requested data formats for interfaces between the Issuer's systems and the Exchange's systems in a timely fashion.

6.4.1.9 Applicant must be prepared and able to conduct testing of data interfaces with the Exchange no later than July 1, 2015 and confirms it will plan and implement testing jointly with Covered California in order to meet system release schedules.

6.4.1.10 Will the secure online tools provided by your organization for the Exchange program staff and members be available 99.5 percent of the time, twenty-four (24) hours a day, seven (7) days a week? If no, describe level of guaranteed availability.

Yes

No

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

Yes

No

6.4.1.12 Do you provide secure online tools for analysis of member utilization and cost trends? Describe below.

Yes

No

6.4.1.13 Indicate (1) the types of data and reporting available to the Exchange on health management and chronic conditions, and (2) the sources of data used to generate the types of reports available to the Exchange. The Exchange expects plans to help assess and improve health status of their Exchange members using a variety of sources. Check all that apply.

	Report Features	Sources of Data
Cost	<i>Multiple-choice</i> 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Report available for additional fee 5: Data/reporting not available	<i>Multiple-choice</i> 1: HRAs 2: Medical Claims Data 3: Pharmacy Claims Data 4: Lab Values 5: Other source - please detail below
Utilization	<i>Same as above</i>	<i>Same as above</i>
Chronic Condition Prevalence	<i>Same as above</i>	<i>Same as above</i>
Plan Enrollee Use of Preventive Services	<i>Same as above</i>	<i>Same as above</i>
Participant Population stratified by Risk and/or Risk Factors	<i>Same as above</i>	<i>Same as above</i>
Disease Management (DM) program enrollment	<i>Same as above</i>	<i>Same as above</i>
Health status change among DM enrollees	<i>Same as above</i>	<i>Same as above</i>

6.4.1.14 Performance Measurement capacity: Applicant must designate, as applicable, which of the following performance measures it measures currently, or could measure in the future, for Exchange-specific products. The specific performance metrics noted after the bullet points are performance levels Covered California will require.

Performance Measure	Measure Now Yes/No	Can Measure Exchange-Specific
Operational Standards – Customer Service		
Call Answer Timeliness <ul style="list-style-type: none"> 80% of calls answered within 30 seconds 		
Processing ID Cards <ul style="list-style-type: none"> For the Individual Exchange, 99% sent within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer. For SHOP, 99% sent within 10 business days of receiving complete and accurate enrollment information for a specific consumer. 		
Number of ID Cards Issued <ul style="list-style-type: none"> Number of initial ID cards processed and issued to the consumer 		
Telephone Abandonment Rate <ul style="list-style-type: none"> No more than 3% of incoming calls in a calendar month 		
Abandoned Call Volume <ul style="list-style-type: none"> Number of calls offered to the service center by the ACD, but terminated by the person originating the call outside of the service level (i.e., 30 seconds) 		
Abandonment Rate <ul style="list-style-type: none"> The percentage of calls abandoned, calculated by dividing the Abandoned Call Volume by the Inbound Call Volume 		
Average Handling Time <ul style="list-style-type: none"> The average number of minutes of talk time, hold time, and wrap time necessary to complete the interaction 		
Initial Call Resolution for Covered California <ul style="list-style-type: none"> 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 		
Grievance Resolution <ul style="list-style-type: none"> 95% of enrollee grievances resolved within 30 calendar days of initial receipt 		
Operational Standards		
Enrollment and Payment Transactions <ul style="list-style-type: none"> The Exchange will receive the 999 file within two to three business days of receipt of the 834 file 85% of the time. 		
Reconciliation of Pended Status Enrollee(s) <ul style="list-style-type: none"> The Exchange will receive the effectuation file within 60 business days from effective date of member 90% of the time. 		
Reconciliation Process <ul style="list-style-type: none"> For non-payment the Exchange will receive an 834 cancellation file within 60 days of the member-intended effective date 90% of the time. 		
Number of Binder Payment Notices Generated – Individual Exchange		

<ul style="list-style-type: none"> Number of initial binder payment notices generated and mailed to the consumer 		
Number of Binder Payments Processed – Individual Exchange <ul style="list-style-type: none"> Number of binder payments paid-in-full and processed 		
Binder Payment Processing Time – Individual Exchange <ul style="list-style-type: none"> Time elapsed from the date the binder payment invoice was mailed for a specific consumer(s) through the date the carrier received the binder payment from that consumer(s) – 		
Member Email or Written Inquiries <ul style="list-style-type: none"> Total number of member email or written inquiries received 		
Member Email or Written Inquiries <ul style="list-style-type: none"> 90% of email or written inquiries answered within 15 business days of inquiry (does not include grievances or appeals) 		
Member Call Volume <ul style="list-style-type: none"> Track only – no performance requirement or penalty 		
Quality Standards		
Quality – Getting the Right Care		
Appropriate Care		
Appropriate Testing for Children With Pharyngitis		
Appropriate Treatment for Children With Upper Respiratory Infection		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Use of Imaging Studies for Low Back Pain		
All-Cause Readmissions		
Annual Monitoring for Patients with Persistent Medications		
Plan All-Cause Readmission (average adjusted probability of readmission)		
Diabetes Care		
CDC: Medical Attention for Nephropathy		
CDC: Hemoglobin-A1c Testing		
CDC: LDL-C Screening		
CDC: Eye Exam (Retinal) Performed		
CDC: LCL-C Control (<100 mg/dl)		
CDC: HbA1c Control (<8.0%)		
CDC: Blood Pressure Control (140/90 mm Hg)		
CDC: HbA1c Poorly Control (>9.0%)		
Cardiovascular Care		
Controlling High Blood Pressure		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)		
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)		
Persistence of beta blocker treatment after a heart attack		

Behavioral Health Care		
Antidepressant Medication Management (Both Rates)		
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only)		
Follow-Up for Children Prescribed ADHD Medication (Both Rates)		
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs and 18+ Yrs)		
Other Chronic Care		
Medication Management for People With Asthma (50%/75% remained on controller medications)		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
Drug Therapy for Rheumatoid Arthritis		
Pharmacotherapy management of COPD Exacerbation (bronchodilator and systemic corticosteroid)		
Doctor and Care Ratings		
Global Rating of Care (CAHPS)		
Global Rating of Personal Doctor (CAHPS)		
Global Rating of Specialist (CAHPS)		
Quality – Access to Care		
Getting Care Quickly Composite (CAHPS)		
Getting Needed Care Composite (CAHPS)		
Child and Adolescent Access to Primary Care Practitioners (12-24 months, 25 months-6 years, 7-11 years, 12-19 years) (HEDIS)		
Adults' Access to Preventive/Ambulatory Health Services (20-44 years and 45-64 years) (HEDIS)		
Quality - Staying Healthy/Prevention		
Adult Staying Health/Prevention		
Checking for Cancer		
Breast Cancer Screening		
Cervical Cancer Screening		
Colorectal Cancer Screening		
Getting Help Staying Healthy		
Chlamydia Screening in Women (Age 21-24)		
Adult BMI Assessment		
Prenatal and Postpartum Care (Both Rates)		
Flu Shots for Adults (Ages 50-64) (CAHPS)		
Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)		
Aspirin Use and Discussion (CAHPS)		
Children and Adolescent Staying Healthy/Prevention		
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents		
Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life		
Well Child Visits in the First 15 Months of Life		
Adolescent Well-Care Visits		
Immunizations for Adolescents		

Childhood Immunization Status – Combo 3		
Chlamydia Screening in Women (Age 16-20)		
Quality – Plan Service		
Claims Processing Composite (CAHPS)		
Customer Service Composite (CAHPS)		
Plan Information on Costs Composite (CAHPS)		
Global Rating of Plan (CAHPS)		

6.4.1.15 Applicant must confirm that it operates in compliance with applicable federal and state privacy laws and regulations, and maintains appropriate procedures in place to detect and respond to privacy and security incidents.

- Yes, confirmed
- No, not confirmed

6.4.1.16 Applicant must confirm it has in place administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Personally Identifiable Information that it creates, receives, maintains, or transmits.

- Yes, confirmed
- No, not confirmed

6.4.2 Financial Interface Capacity

6.4.2.1 Applicant must confirm it has in place systems to invoice new members effective October 15, 2015. If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to invoicing, if applicable, and an implementation workplan.

- Yes, confirmed
- No, not confirmed

6.4.2.2 Applicant must confirm it has in place systems to accept premium payments (including paper checks, cashier’s checks, money orders, EFT, web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment) from members effective October 1, 2015. If such systems are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation workplan. QHP must accept premium payment from members no later than October 1, 2015. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

- Yes, confirmed

- No, not confirmed

6.4.2.3 Describe how Applicant will comply with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for binder and ongoing payments for both on-Exchange and off-Exchange lines of business.

6.4.2.4 Applicant must confirm it can provide detailed documentation, including member level detail, to substantiate each per-member per-month (PMPM) participation fee payment in a format that is compatible with Covered California's systems.

6.4.2.5 Applicant agrees not to impose any fees or charges on any members who request paper invoices for premiums due for any individual products sold by issuer in California.

6.5 IMPLEMENTATION PERFORMANCE

6.5.1 Will an implementation manager and support team (not part of the regular account management team) be assigned to lead and coordinate the implementation activities with the Exchange? If yes, specify the name and title(s) of the individual(s).

6.5.2 Should your organization's QHPs be certified by the Exchange, explain how you anticipate accommodating the additional membership effective January 1, 2016. Discuss assessment of current resources (human, office space, phone capacity), anticipated hiring needs, staff reorganization, etc.:

- Member Services
- Claims
- Account Management
- Clinical staff
- Disease Management staff
- Implementation
- Financial
- Administrative
- Actuarial
- Information Technology
- Other (describe)

6.5.3 Indicate your current or planned procedures for managing the new enrollee transition period. Check all that apply:

- Request transfer from prior health or dental plan, if applicable, and utilize information to continue plan/benefit accumulators
- Load claim history from prior health or dental plan, if any
- Services that have been pre-certified but not completed as of the effective date must also be pre-certified by new plan
- Will provide pre-enrollment materials to potential Enrollees within standard fees
- Will make customer service line available to new or potential Enrollees prior to the effective date
- Provide member communications regarding change in health or dental plans

6.5.4 Describe your network transition of care provisions for patients who are currently receiving care for services at practitioners that are not in your network. Specifically describe plans for transitions of care for the following: 1) pregnant women currently receiving care from a non-network provider, 2) enrollees receiving a course of treatment such as chemotherapy, or scheduled for an invasive procedure. Describe any other transition of care services provided by Applicant.

6.5.5 Provide a detailed implementation project plan and schedule targeting a January 1, 2016 effective date.

6.6 FRAUD, WASTE AND ABUSE DETECTION

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

Fraud - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste - Waste is the intentional or unintentional, thoughtless or careless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse – Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The

practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings.

6.6.1 Describe the processes used in addressing fraud, waste, and abuse for the following:

Process	Description
Determining what is investigated: <ul style="list-style-type: none"> • Specific event triggers, • Overall surveillance, audits and • Fraud risk assessment 	
Method for determining whether fraud, waste, and abuse has occurred	
Follow-up and corrective measures	
Recovery and remittance of funds	

6.6.2 Describe your approach to the following:

Approach	Description
Controls in place to confirm non-contracted Providers who file Claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.	
Use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.	
Controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.	

Controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.	
Other	

6.6.3 Provide a brief description of your fraud detection policies (i.e., fraud as it relates to Providers and Plan Members).

Providers	
Plan Members	

6.6.4 Provide a sample copy of your fraud, waste, and abuse report.

- Sample provided
- Sample not provided

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

	Daily	Weekly	Monthly	Quarterly	Other (Specify)
Claims Administration					
Customer Service					
Network Contracting					
Eligibility & Enrollment					
Utilization Management					
Billing					

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

%

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

	Audit Conducted	Audit Not Conducted
Most recent year		
Prior year		

6.6.8 Indicate the types of Claims and Providers that you typically review for possible fraudulent activity. Check all that apply.

- Hospitals
- Physicians
- Skilled nursing
- Chiropractic
- Podiatry
- Behavioral Health
- Alternative medical care
- Durable medical equipment Providers
- Other service Providers

6.6.9 Describe the different approaches you take to monitor these types of Providers.

6.6.10 Specify your system for flagging unusual patterns of care. Check all that apply:

- Identified at time of Claim submission
- Data mining
- Plan Member referrals
- Other – Specify

6.6.11 What was your organization's recovery success rate and dollars recovered for fraudulent Claims?

	%	\$
2012		
2013		

6.6.12 Applicant must confirm that, if certified, it will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the Department of General Services, the California State Auditor or its designee, as

they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and Advance Premium Tax Credit (APTC) payments and participation fee payments Issuer made to the Exchange. Issuer also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

- Yes, confirmed
- No, not confirmed

6.6.13 Describe your revenue recovery process to recoup erroneously paid claims.

6.6.14 Describe how you educate your members to identify and report possible fraud scams. What are your procedures to report fraud scams to law enforcement?

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

6.7 APPROACHES TO ENROLLMENT

Covered California achieves enrollment through a variety of partnerships including navigators, Certified Insurance Agents and Certified Plan-Based Enrollers.

6.7.1. Describe any experience you may have working with navigators or similar entities.

6.7.2 Describe any experience you have working with Certified Insurance Agents or licensed agents.

6.7.2.1 What initiatives is your organization undertaking in order to partner more effectively with the small business community?

6.7.2.2 What initiatives is your organization undertaking in order to partner more effectively with the agent community?

6.7.2.3 What criteria do you use to appoint agents to sell Individual and Small Group products?

6.7.2.4 Does your health plan contract with general agents? If so, please list the general agents with whom you contract and how long you have maintained those relationships.

6.7.2.5 Describe your health plan agent commission schedule for your individual and small group business. Include whether or not the compensation level changes as the business written by the agent matures, and also specify if the agent is compensated at a higher level as he or she attains certain levels/amounts of inforce business. Does the compensation level apply to all plans or benefits or does it vary by plan or benefits?

6.7.2.6 Describe any bonus program your company currently has in place for additional agent compensation. This may include cash bonuses or in-kind compensation programs. Please answer this question relative to general agents as well.

6.7.3 Describe any experience you may have performing plan-based enrollment.

6.8 MARKETING AND OUTREACH ACTIVITIES

The Exchange is committed to working closely with QHPs to maximize enrollment in the Exchange. The Exchange will support enrollment efforts through outreach and education, including statewide advertising efforts aimed at prospective and existing members of the Covered California Health Benefit Exchange. QHP Issuers are required to develop and execute their own marketing plans to promote the enrollment in their respective Exchange plans. Contracted QHPs will adhere to Covered California Brand Style Guidelines for specific requirements regarding a QHP's use of the Exchange brand name, logo, and taglines. Contracted QHPs will also adhere to QHP Marketing Guidelines, including requirements for development, submission, and timing of QHP marketing plans and materials.

In the questions that follow, Applicants must provide detailed information pertaining to the Applicant's plans for marketing and advertising for the individual and small group market.

6.8.1 Applicant must provide an organizational chart of its individual and small group sales and marketing department(s) and identify the individual(s) with primary responsibility for sales and marketing of the Exchange account. Indicate where these individuals fit into the organizational chart. Include the following information:

- Name
- Title
- Department
- Phone
- Fax
- E-mail

6.8.2 Applicant must describe its plan to cooperate with Exchange marketing and outreach efforts, including internal and external training, collateral materials and other efforts.

6.8.3 Applicant must confirm that, upon certification, it will adhere to Exchange requirements to co-brand ID cards, premium invoices, and termination notices issued to Exchange enrollees. The Exchange retains the right to communicate with Exchange customers and members.

- Yes, confirmed
- No, not confirmed

6.8.4 Applicant must provide a copy of the most recent Calendar Year or Fiscal Year Marketing Plan for the current lines of business. Applicants serving the Medi-Cal Managed Care population shall report such marketing as “Individual” marketing.

6.8.5 Applicant must indicate estimated total expenditures and allocations for Individual and Small Group related marketing and advertising functions during the most recent Calendar Year/Fiscal Year. Using the table below, Applicant must provide a detailed picture of how this Individual and Small Group funding commitment was applied. Indicate N/A if the Applicant did not market Individual or Small Group products in the most recent period.

Marketing Results	Total Cost		Total Sales		Cost per Sale	
	Individual	Small Group	Individual	Small Group	Individual	Small Group
Television (media investment only)						
Radio (media investment only)						
Out-of-Home (media investment only)						
Newsprint (media investment only)						
FSI (Free Standing Inserts) (media investment only)						
Direct Mail (list cost, postage, printing/fulfillment)						
Shared Mail (media investment only)						
Search Engine Marketing (media investment only)						
Digital (display, video, mobile, radio)						

(media investment only)						
Social Media (media investment only)						
Email Marketing (list and deployment costs)						
Lead Purchase						
Broker Seminars			N/A	N/A	N/A	N/A
Direct Sales to Businesses						
Other (specify)						

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

7. QUALITY AND DELIVERY SYSTEM REFORM

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 Quality and Delivery System Reform standards outlined in the QHP Contract outline the ways the Exchange and Contracted QHPs will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers.

7.1 ACCREDITATION

Applicant must be currently accredited by Utilization Review Accreditation Commission (URAC), National Committee on Quality Assurance (NCQA) or Accreditation Association for Ambulatory Health Care (AAAHC). If issuer is not currently accredited, issuer must have an interim survey in place by January 1, 2016 in order to offer plans on the Exchange in 2016. QHPs must have full accreditation by January 1, 2017. Issuer shall authorize the accrediting agency to provide information and data to the Exchange relating to Issuer's accreditation, including, the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

7.1.1 Specify the accrediting organization (National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)). Specify current accreditation status, expiration date of accreditation, next scheduled survey date(s) and proposed timeline if full accreditation has not been achieved or maintained.

NCQA ___

Exchange-specific accreditation (if applicable) ___

URAC ___

Exchange-specific accreditation (if applicable) ___

AAHC ___

Exchange-specific accreditation (if applicable) ___

7.1.2 For applicants accredited by NCQA, provide the current accreditation status

- a. Excellent
- b. Commendable
- c. Accredited
- d. Provisional
- e. Interim
- f. Denied

7.1.3 Enter the expiration date

a. Expires: __/__/__

7.1.4 Next scheduled survey date

- a. Date: __/__/__
- b. Next survey date not scheduled

7.1.5 Attach a copy of the NCQA Certificate of Accreditation. If the health plan received a rating of less than “accredited,” attach a copy of the corrective action plan.

7.1.6 For applicants accredited by URAC, provide the current accreditation status.

- a. Full accreditation
- b. Provisional accreditation as a start-up
- c. Conditional accreditation
- d. In process

7.1.7 Enter the expiration date

a. Expires __/__/__

7.1.8 Next scheduled survey date

a. Date: __/__/__

b. Next survey date not scheduled

7.1.9 Attach a copy of the URAC Certificate of Accreditation. If the health plan received conditional accreditation, attach a copy of the corrective action plan.

7.1.10 For applicants accredited by AAAHC, provide the current accreditation status

a. AAAHC Accredited

7.1.11 Enter the expiration date

a. Expires: __/__/__

7.1.12 Next scheduled survey date

a. Date: __/__/__

b. Next survey date not scheduled

7.1.13 Attach a copy of the AAAHC Certificate of Accreditation

7.2 eVALUE8 SUBMISSION

7.2.1 Applicant must complete the eValue8 Request for Information submission as specified in Section 8 of this application.

7.3 QUALITY IMPROVEMENT STRATEGY

As part of a Quality Improvement Strategy, identify the mechanisms the Applicant intends to use to promote improvements in health care quality, better prevention and wellness and making care more affordable. These mechanisms may include plan designs that reduce barriers or provide incentives for preventive or wellness services. The Exchange will give more weight to those responses from Applicants that engage in programs that foster payment and other practices that encourage primary care, care coordination, quality improvement, promoting health equity and reducing costs.

7.3.1 Applicant must describe their past or current initiatives in these areas in the sections that follow and in the eValue8 sections. See Section 9 SHOP Supplemental Application to complete additional detail regarding the availability of financial incentives in SHOP products.

Preventive and Wellness Services	Available in Individual Exchange	Available in SHOP Exchange	SHOP Exchange Financial Incentives
Health Assessment Offered	Yes/No	Yes/No	Yes/No
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	AS ABOVE
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	AS ABOVE
Tobacco Cessation Program	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Stress Management	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Mental Health	AS ABOVE	AS ABOVE	AS ABOVE
OTHER	AS ABOVE	AS ABOVE	AS ABOVE

7.3.2 Describe two Quality Improvement Projects (QIPs) conducted within the last five (5) years. Include information about results of the QIP, why the QIP was undertaken and why it ended or has continued, if applicable. Describe the QIP scalability, if it was successful. Also include the following information:

QIP Name/Title:	Start/End Dates:
Problem Addressed:	
Targeted Population:	
Study Question:	
Study Indicator(s):	
Baseline Measurement:	
Best Practices Related to Sustained Improvement Achieved (if any):	

7.4 MEDICAL MANAGEMENT SERVICES

7.4.1 Do you provide physician report cards? If so, do you use external guidelines to measure physician performance? Describe those procedures and processes. Also describe how the information is shared with consumers.

If you do not provide physician report cards, describe why. Describe if there are plans to implement such report cards or other methods used to evaluate provider quality performance and how that is shared with consumers.

Process	Yes/No	If Yes, description	Description of consumer access to physician performance
Internally Developed Guidelines			
External Guidelines <ul style="list-style-type: none"> • National Quality Forum • Patient Charter for Physician Performance Measurement 			
Other			

7.4.2 Do you provide a Nurse Advice Line? If so, what percentage of eligible members currently accesses the Nurse Advice Line?

- Yes, provide Nurse Advice Line:
 - 0-5%
 - 6-10%
 - 11-20%
 - 21-30%
 - >31%
- Nurse Advice Line not provided

If you do not provide an advice line, describe how enrollees access assistance after hours related to clinical questions.

If utilization of nurse advice line is below 20%, describe plans to reach consumers and assist them with clinical questions.

7.4.3 Indicate the availability of the following health information resources for Covered California members. (Check all that apply)

- 24/7 decision support/health information services

- Self-care books
- Preventive care reminders
- Web-based health information
- Integration with other health care vendors
- Integration with a client's internal wellness program
- Newsletter
- Other (describe)

7.4.4 Explain how your health plan encourages hospitals and other providers to improve patient safety on an ongoing basis. The focus should be on quality improvement, not claims payment determination. How is information collected and used to improve care and safety for members as well as to provide feedback to providers to improve their care?

Describe any oversight your health plan performs targeting the following areas as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program:

- Deaths and readmissions,
- Serious complications related to specific conditions,
- Hospital-acquired conditions,
- Health care associated infections.

7.5 BEHAVIORAL HEALTH MEDICAL MANAGEMENT

7.5.1 Do you manage Behavioral Health services in-house or do you subcontract? How do you incorporate behavioral health information in identifying members for care management programs or interventions?

7.5.2 Describe how you incorporate Evidence-Based Medicine and monitor outcomes to institute and assess best practices for behavioral health. Include a description of your efforts to assess and modify networks and implement best practices that would meet the specific needs of the Exchange population demographics.

7.5.3 What are your recent actual managed behavioral health network results?

	Actual
Bed days/1,000 members	
Professional encounters/1,000 members	

7.6 HEALTH AND DISEASE MANAGEMENT

If selected, QHP Applicant will be required to demonstrate the capacity and systems to collect, maintain and make use of individual information about Plan Enrollees’ health status and behaviors to promote better health and to better manage Enrollee’s health conditions. If a Health Assessment tool is used, Contracted QHP shall use a tool that allows for the monitoring of ongoing Enrollee health status. Contracted QHPs will report to the Exchange, at the individual and aggregate levels, changes in Plan Enrollees’ health status and outcomes of referral to care management and chronic condition programs based on identification of decline in health status through health assessment process.

7.6.1 Does your health plan use a Health Assessment? Identify which of the following you perform using Health Assessment (“HA”) data.

	Yes	No
Populate a personal health record with the information		
Personalize/tailor messages on preventive reminders		
Provide action steps for members to take		
Send a reminder when it is time to take next HA		
Relay data to providers		
Refer to lifestyle management programs (online and telephonic)		
Refer to disease management programs		
Assess/stratify risk using both HA and claims data mining		

7.6.2 Which of the following are communicated to Members? (Check all that apply):

- Pharmacy compliance reminders
- Personalized reminders for screenings and immunizations

- Plan monitors whether member has received indicated screenings and immunizations and can provide aggregated reports of the percentage of members that have received these.
- None of the above

7.6.3 Provide or describe three examples of preventive care notifications currently in use by your health plan.

7.7 INTEGRATED HEALTHCARE MODEL

The Exchange is interested in how Applicants plan to address components of an Integrated Healthcare Model:

An integrated model of health care delivery is one in which there is organizational/operational/policy infrastructure addressing patient care across the continuum of care, population management and improvements in care delivery, IT infrastructure to support care delivery, adherence to Evidence Based Medicine (EBM) behaviors from all providers of care, and financial risk sharing incentives for the health plan, hospital, and medical group that drive continuous improvement in cost, quality, and service.

7.7.1 From an organizational/operational/policy perspective, Applicant must indicate if its delivery model addresses the following, providing descriptions where applicable:

Attribute	Description
Describe your processes to coordinate care management in the following areas:	
a. Transitional Care	
b. Long Term/Catastrophic Care	
c. End of Life Care	

7.7.2 What national sources of Evidence Based Medicine practice guidelines do you use? List all that apply, e.g., Agency for Healthcare Research and Quality, Milliman guidelines.

7.7.3 Describe any requirements you may have for your contracted hospitals to report performance information based on the National Quality Forum consensus measures.

<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69376>

If your plan does not require reporting of such performance information, explain plans to implement such performance monitoring and reporting.

7.7.4 Describe your measurement strategy and any specific ability to track impact on Exchange enrollees for the following areas:

Strategy	Description
Describe your policies in place to address population health management across enrolled Members.	
Describe your ability to track Exchange-specific IHM metrics supporting risk-sharing arrangements.	
Describe your processes, if any, to track and monitor clinical and financial performance measurement related to the Integrated Healthcare Association (IHA).	
Describe your ability to track and monitor Exchange-specific data in the following areas:	
a. Member satisfaction	
b. Cost and utilization management (e.g., admission rates, complication rates, readmissions)	
c. Clinical outcome quality	

7.7.5 For your networks, describe your policies to support and give examples of how you support the following:

Attribute	Description
Disease registries	
Ability to identify overuse, under-utilization, and misuse of services	
Access to data by Providers and Members across the continuum of care (e.g., Physicians, Hospitalists, Case Managers, etc.)	
Decision support for Member and Physician interaction in care management	

7.8 INNOVATIONS

7.8.1 Describe your institutional capacity to plan, implement, and evaluate future healthcare quality and cost innovations for Exchange Members. Include a description of plans for scalability or replicability of successful innovations. Of special interest to the Exchange are programs that target at-risk enrollees (e.g.: communities at risk for health disparities, enrollees with chronic-conditions and those who live in medically underserved areas).

7.8.2 Covered California seeks to conduct advanced analytics to assess performance of both the Exchange and its contracted health plans for the benefit of its enrollees. These expectations for Covered California enrollees mean significant clinical and network analytics capacity are needed by each QHP. Describe your infrastructure, available or currently in use, for clinical and network analytics.

If selected, Applicant must submit claims and encounter data to an Exchange-identified analytics vendor to facilitate analytics and innovations based on data. Vendor will aggregate data elements related to the following areas:

- Provider network adequacy
- Risk mix and segmentation
- QHP quality
- High severity of illness patient care
- Care management/integration services
- Health disparities reduction
- Hospital quality
- Physician reporting -- patient care interventions
- Care continuity
- Enrollee choice of doctor, practice or medical group -- physician and practice performance ratings
- Enrollee affordability of care
- Payment and benefit design innovation

Applicant agrees to submit claims and encounter data to Exchange-identified analytics vendor.

Covered California

Yes

No

8. eVALUE8™ SUBMISSION – eVALUE8 REQUEST FOR INFORMATION

8.1 BUSINESS PROFILE

8.1.1 Instructions

8.1.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

8.1.1.2 All attachments to this module must be labeled as "Profile #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Profile 1a, Profile 1b, etc.

8.1.1.3 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. The PPO question always follows the HMO question. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been auto-populated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question below in 1.1.5.

8.1.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

8.1.1.5 Plan is responding for the following products

Multi, Checkboxes.

- 1: HMO/POS,
- 2: PPO

8.1.1.6 **No Plan action needed. This question is to be completed by the reviewer.** Scoring is currently being computed for the following product: (Changing the answer causes scores to be recomputed.)

Single, Radio group.

- 1: HMO/POS,
- 2: PPO

8.1.2 Contact and Organization Information

8.1.2.1 Provide the information below for the local office of the Plan for which this RFI response is being submitted.

	Answer
Corporate Name	<i>Unlimited.</i>
Local Plan Name (if different)	<i>Unlimited. Nothing required</i>
Plan Street Address (1)	<i>200 words.</i>
Plan Street Address (2)	<i>20 words. Nothing required</i>
Plan City	<i>Unlimited.</i>
Plan State (2 character abbreviation)	<i>Unlimited.</i>
Plan Zip	<i>Unlimited.</i>
Plan Telephone (999) 999-9999	<i>Unlimited.</i>
Plan Fax (999) 999-9999	<i>Unlimited.</i>
Plan Website URL	<i>Unlimited.</i>

Covered California

8.1.2.2 Complete the table below for the individuals responsible for the market for which this RFI response is being submitted.

	Contact Name	Title	Phone (include extension)	Fax	E-mail
Primary Contact (for RFI)	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
Secondary Contact	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
Other	<i>Unlimited. Nothing required</i>	<i>Unlimited. Nothing required</i>	<i>Unlimited. Nothing required</i>	<i>Unlimited. Nothing required</i>	<i>Unlimited. Nothing required</i>

8.1.2.3 Tax Status

Single, Pull-down list.

- 1: Profit,
2: Non-Profit

8.1.2.4 Did ownership change in 2014 or is a change being considered in 2015?

Single, Pull-down list.

- 1: Yes (describe);
2: No

8.1.3 Market Position

8.1.3.1 If plan is responding for HMO and/or PPO products and has not made a selection in 1.1.5 – please do so before proceeding so that the appropriate questions are active.

8.1.3.2 Identify the Plan membership in each of the products specified below **within the response market as of 12/31/14**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers. Please copy this response into the following questions 8.1.3.3 and 8.1.3.4.

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Fully-insured, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Other (describe in "Other Information")	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Total	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>

8.1.3.3 Identify the Plan membership in each of the products specified below **for the state of California as of 12/31/14**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers across the country.

Plans that operate in ONLY one market should copy their response from previous question to this question as numbers in 1.3.3 are used to autopopulate some responses in other modules.

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Fully-insured, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Other (describe in "Other Information")	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Total	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>	<i>For comparison. 0</i>

Covered California

8.1.3.4 Identify the Plan membership in each of the products specified below **nationally as of 12/31/14**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers.

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Fully-insured, Plan administered	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Other (describe in "Other Information")	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Decimal.</i>
Total	<i>For comparison.</i> 0	<i>For comparison.</i> 0	<i>For comparison.</i> 0	<i>For comparison.</i> 0	<i>For comparison.</i> 0

8.1.3.5 Please provide a signed Attestation of Accuracy form. A template version of the document is attached and can be downloaded from the documents manager. Please label as Profile 1.

Single, Radio group.

- 1: Yes, a signed version of the attestation is attached.
- 2: Not provided

8.1.4 Accreditation and CAHPS Performance

8.1.4.1 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply. For the URAC Accreditation option, please enter each expiration date in the detail box if the Plan has earned multiple URAC accreditations.

This question needs to be answered in entirety by the Plan. Note that plan response about NCQA PHQ Certification should be consistent with plan response in question #2.7.1 in module 2 on the Consumer Disclosure project where PHQ is a response option.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA MCO	<i>Single, Pull-down list.</i> 1: Excellent, 2: Commendable, 3: Accredited, 4: Provisional 5: Interim 6: Denied 7: NCQA not used or product not eligible	<i>To the day.</i> From Dec 30, 1972 to Dec 31, 2022.	
NCQA Exchange	<i>Single, Pull-down list.</i> 1: Completed Health Plan Add-On Application. 2: Interim. 3: First 4: Renewal	<i>To the day.</i> From Dec 30, 1972 to Dec 31, 2022.	
NCQA Wellness & Health Promotion Accreditation	<i>Single, Radio group.</i> 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	<i>To the day.</i> From Dec 30, 1972 to Dec 31, 2022.	<i>Unlimited.</i>
NCQA Disease Management – Accreditation	<i>Multi, Checkboxes.</i> 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	<i>To the day.</i> From Dec 30, 1972 to Dec 31, 2022.	<i>Unlimited.</i>
NCQA Disease Management – Certification	<i>Multi, Checkboxes.</i> 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	<i>To the day.</i> From Dec 30, 1972 to Dec 31, 2022.	<i>Unlimited.</i>
NCQA PHQ Certification	<i>Single, Pull-down list.</i> 1: Certified, 2: No PHQ Certification	<i>To the day.</i> From Dec 30, 1971 to Dec 31, 2022.	
URAC Accreditations	<i>Multi, Checkboxes - optional.</i> 1: URAC not used		
URAC Accreditations - Health Plan	<i>Single, Radio group.</i> 1: URAC Accredited, 2: Not URAC Accredited	<i>To the day.</i> From Dec 31, 1972 to Jan 01, 2023.	
URAC Accreditation - Comprehensive Wellness	AS ABOVE	AS ABOVE	

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URAC Accreditations - Disease Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Health Utilization Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Case Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Pharmacy Benefit Management	AS ABOVE	AS ABOVE	

8.1.4.2 PPO version of above.

8.1.4.3 Review the Plan's HMO CAHPS ratings for the following composite measures. **Note only 9 & 10 responses provided and not the 8, 9, & 10 responses.**

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by Health Benefit Exchange (individually).

	HMO QC 2014	HMO QC 2013
Rating of Health Plan (9+10)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Rating of All Health Care (9+10)	AS ABOVE	AS ABOVE

8.1.4.4 PPO version of above.

8.1.5 Business Practices and Results

8.1.5.1 Identify the sources of information used to gather commercial members' race/ethnicity, primary language and interpreter need. **The response "Enrollment Form" pertains only to information reported directly by members (or as passed on from employers about specific members).**

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

	Data proactively collected from all new enrollees (specify date started - MM/DD/YYYY)	How data is captured from previously enrolled members (i.e., those who were not new enrollees when respondent started collecting information) - specify method	Members captured as percent of total commercial population (statewide)
Race/ethnicity	<i>To the day.</i> N/A OK.	<i>Multi, Checkboxes.</i> 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	<i>Percent.</i>
Primary language	<i>To the day.</i> N/A OK.	AS ABOVE	<i>Percent.</i>
Interpreter need	<i>To the day.</i> N/A OK.	AS ABOVE	<i>Percent.</i>
Education level	<i>To the day.</i> N/A OK.	AS ABOVE	<i>Percent.</i>

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

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

	Physicians in this market	Physician office staff in this market	Plan staff in this market
Race/ethnicity	<i>Percent.</i> From 0 to 100.	<i>Percent.</i> From 0 to 100.	<i>Percent.</i> From 0 to 100.
Languages spoken	AS ABOVE	AS ABOVE	AS ABOVE

8.1.5.3 For commercial book of business please indicate if the health plan provides any of the services below and indicate whether such services are internally developed or contracted. In the detail box, provide a description of the health plan's strategy to incorporate social media as a consumer engagement and decision support tool, including program metrics and evaluation criteria

	Service Provided	Name external vendor or Apps and/or pilot markets	Date Implemented	Access/Availability
Online discussion forum for member feedback	<i>Multi, Checkboxes.</i> 1: Internally developed, 2: External vendor - name vendor in following column, 3: Service not provided, 4: Service being piloted - list location in following column	65 words.	To the day. From Dec 31, 1981 to Dec 31, 2021.	<i>Multi, Checkboxes.</i> 1: Standard benefit for all fully insured lives (included in fully insured premium), 2: Standard benefit for all self insured ASO lives (no additional fee), 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members
Mobile applications for self-care	AS ABOVE			AS ABOVE
Mobile applications for self-care and automated biometric tracking	AS ABOVE			AS ABOVE
Condition-specific information feed (e.g., phone text health reminders)	AS ABOVE			AS ABOVE
Other (describe below)	AS ABOVE			AS ABOVE

8.1.6 Collaborative Practices

8.1.6.1 Is the Plan engaged in any of the following nationally organized programs in the market of this RFI response? Identify other markets of engagement. List any ACO contracts that became effective in this market on 1/1/2015 in other information section at end of this module

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 Plan is not engaged in any of the below programs	<i>Multi, Checkboxes - optional.</i> 1: Not Engaged in Any Programs		
Leapfrog Hospital Rewards Program	<i>Single, Radio group.</i> 1: Engaged, 2: Not Engaged	<i>Single, Radio group.</i> 1: Engaged, 2: Not Engaged	50 words.
Prometheus	AS ABOVE	AS ABOVE	AS ABOVE
Bridges to Excellence	AS ABOVE	AS ABOVE	AS ABOVE
Aligning Forces for Quality	AS ABOVE	AS ABOVE	AS ABOVE
Chartered Value Exchange	AS ABOVE	AS ABOVE	AS ABOVE

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Health Map RX (Asheville Project)	AS ABOVE	AS ABOVE	AS ABOVE
Multi-payer Medical Home (name additional payers in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Accountable care organizations (name groups and hospitals under contract in response market in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Purchaser-organized programs (e.g., Xerox in Rochester, NY) described in detail box	AS ABOVE	AS ABOVE	AS ABOVE
California Hospital Assessment and Reporting Taskforce (CHART)	AS ABOVE	AS ABOVE	AS ABOVE
California Health Performance Information System (CHPI)	AS ABOVE	AS ABOVE	AS ABOVE
Integrated Healthcare Association (IHA) Pay for Performance Program	AS ABOVE	AS ABOVE	AS ABOVE
IHA Division of Financial Responsibility (DOFR) (Describe in detail box your organization's current use, if any, of DOFRs with providers. If applicable, identify the percentage of providers utilizing DOFRs and describe any plans to increase usage.)	AS ABOVE	AS ABOVE	AS ABOVE
Other (described in detail box)	AS ABOVE	AS ABOVE	AS ABOVE

8.1.6.2 Identify collaborative activities with other local health plans and/or purchasers in the community on implementation of data pooling and/or agreement on common measures to support variety of activities noted below (such as payment rewards, consumer reporting) in the local market for this RFI response related to physician measurement. Collaboration solely with a parent/owner organization or Plan vendors does NOT qualify for credit. Name the other participants for each type of collaboration. Implementation refers to the go-live date marking the beginning of use of the data for the listed purpose. **A given activity can be reported for credit as long as data continues to be actively pooled for the stated purpose.** Plans are also given the opportunity to report on programs that have been implemented by the date of the RFI submission.

The AQA (formerly known as the Ambulatory Care Quality Alliance) founded in the fall of 2004 by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), America's Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), has grown since that time into a broad based collaborative of over 100 organizations, including physicians and other clinicians, consumers, *Purchasers, health insurance plans and others.* Reporting principles (to public, clinicians and hospitals) from the AQA workgroup can be found at: <http://www.aqaalliance.org/reportingwg.htm>

The current mission of the AQA is to improve patient safety, health care quality and value in all settings through a collaborative process in which key stakeholders agree on and promote strategies to:

- implement performance measurement at the physician and other clinician or group level;
- collect and aggregate data in the most appropriate way; and
- report meaningful information to consumers, physicians and other clinicians, and other stakeholders to inform decision-making and improve outcomes

	Types of measures used in activity selected by plan	Name of participating Organizations
Pooling data for physician feedback and benchmarking – implemented and in place at time of RFI submission	<i>Multi, Checkboxes.</i> 1: AQA or Multi-Payer PCMH Clinical Process Measures (e.g., HbA1c testing, preventive screenings), 2: AQA or Multi-Payer PCMH Clinical Outcome Measures (e.g. blood pressure control, LDL <100), 3: Non-AQA or Multi-Payer PCMH clinical quality measures, 4: Standardized measures of patient experience, 5: Standardized measures of episode treatment efficiency, 6: None of the above	50 words.
Pooling data for consumer reporting – implemented and in place at time of RFI submission	AS ABOVE	50 words.

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Pooling data for payment rewards – implemented and in place at time of RFI submission	AS ABOVE	50 words.
Pooling data to generate actionable member-specific reminders – implemented and in place at time of RFI submission	<i>Multi, Checkboxes.</i> 1: AQA or Multi-Payer PCMH Clinical Process Measures (e.g., HbA1c testing, preventive screenings), 2: AQA or Multi-Payer PCMH Clinical Outcome Measures (e.g. blood pressure control, LDL <100), 3: Non-AQA or Multi-Payer PCMH clinical quality measures, 4: None of the above	50 words.
Agreement on common measures for payment rewards in place at time of RFI submission	AS ABOVE	50 words.
Agreement on common measures for consumer reporting in place at time of RFI submission	AS ABOVE	50 words.

8.1.6.3 Identify collaborative activities with other local health plans in community related to agreement on a set of common measures (or other collaborations) for the following hospital performance-related activities (e.g., payment rewards, consumer reporting). **If the State provides hospital reports or the Plan is citing CMS Hospital Compare as its source of collaboration, that source may be claimed as collaboration ONLY IF ALL of the collaborating plans: 1) have agreed on a common approach to the use of State/CMS data by selecting which indicators to use (all or a specific subset) 2) use the State/CMS indicators/data for incentives and/or reporting, and if used for reporting, 3) have at least a hyperlink to the State's/CMS's public reports.**

The Leapfrog Group includes private and public health care purchasers that provide health benefits to more than 34 million Americans and spend more than \$60 billion on health care annually. Information on the four Leapfrog safety practices (CPOE, Evidence-Based Hospital Referral, ICU Physician Staffing, NQF-endorsed Safe Practices) is available at http://www.leapfroggroup.org/for_hospitals/leapfrog_hospital_survey_copy/leapfrog_safety_practices. Name participants for each collaboration. **Agreement must be in place by time of submission for credit to be awarded. If activity has been implemented based on agreement, respond in agreement row and note the implementation date in last column.**

	Types of Measures used in the activity selected by the plan	Name of participating Organizations and description of "other collaboration" in 3rd row
Link to CMS Website only	<i>Single, Radio group.</i> 1: Yes, 2: No	
Agreement on common measures for payment rewards in place at time of RFI submission	<i>Multi, Checkboxes.</i> #1: HQA clinical process measures, #2: Leapfrog measures, #3: Other quality measures endorsed by NQF, #4: Quality outcomes measures (e.g., mortality rates), #5: Standardized measures for patient experience (e.g., H-CAHPS), #6: Efficiency measures, #7: None of the above	100 words.
Agreement on common measures for consumer reporting in place at time of RFI submission	AS ABOVE	100 words.
Other collaboration to support hospital performance improvement in place at time of RFI submission (describe collaboration as well as participating organizations in last column)	AS ABOVE	200 words.

8.1.7 Other Information

8.1.7.1 If the Plan would like to provide additional information about Plan Profile that was not reflected in this section, provide as Profile 3. **List any ACO contracts that became effective in this market on 1/1/2015.**

Single, Pull-down list.
1: Profile 3 (with 4 page limit),
2: No

8.2 PHYSICIAN AND HOSPITAL (PROVIDER) MANAGEMENT AND MEASUREMENT

8.2.1 Instructions and Definitions

8.2.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

8.2.1.2 All attachments to this module must be labeled as "Provider #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Provider 1a, Provider 1b, etc.

8.2.1.3 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5.

8.2.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

8.2.2 Management and Contracting

8.2.2.1 Plans are expected to manage their network and contract renewals to ensure members are held harmless in instances where there are no negotiated contracts with in-network hospital-based physicians (anesthesia, pathology, radiology, ER). Purchasers recognize the dynamics of negotiation and welcome ways in which they might be helpful to motivate hospitals to require hospital-based specialists to provide discounted rates for each plan with which they have contracts.

If the Plan has circumstances where there is no discounted agreement with hospital-based specialists, indicate how claims are treated by HMO.

Information about the Fair Health database can be found at www.fairhealth.org

HMO Response	Treatment of claims if no discounted agreement	Other (limit 100 words)
Self-funded plans	<i>Multi, Checkboxes.</i> 1: Considered in-network, 2: Considered out-of-network, member incurs higher cost-share, 3: All Plan hospital-based specialists have discounted agreement, 4: Employer option to decide, 5: Paid at Usual & Customary based on FairHealth.org information, 6: Other (describe in next column), 7: Unknown	100 words.
Fully-insured plans	AS ABOVE	100 words.

8.2.2.2 Plans are expected to manage their network and contract renewals to ensure members are held harmless in instances where there are no negotiated contracts with in-network hospital-based physicians (anesthesia, pathology, radiology, ER). Purchasers recognize the dynamics of negotiation and welcome ways in which they might be helpful to motivate hospitals to require hospital-based specialists to provide discounted rates for each plan with which they have contracts.

If the Plan has circumstances where there is no discounted agreement with hospital-based specialists, indicate how claims are treated by PPO.

Information about the Fair Health database can be found at www.fairhealth.org

PPO Response	Treatment of claims if no discounted agreement	Other (limit 100 words)
Self-funded plans	AS ABOVE	100 words.
Fully-insured plans	AS ABOVE	100 words.

8.2.2.3 On behalf of Purchasers and to reduce response burden, NBCH and the Catalyst for Payment Reform (CPR) are collaborating on a set of questions to collect and report plan responses with respect to payment reform. This set of questions is flagged as CPR. A subset of questions (2.2.4, 2.8.1, 2.8.4, 2.8.6, 2.11.2, 2.10.1, 2.10.2, 2.10.5) replaced other payment reform questions that were posed in eValue8 2012. The goal of this set of questions on payment reform is to inform and track the nation's progress on payment reform initiatives. CPR received grants from The

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Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from responses to questions. Information on the National Scorecard and Compendium such as a FAQ and methodology can be found at <http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard>. Results of the responses for the National Scorecard are displayed in the aggregate (i.e., health plans will not be identified and there will be no plan-to-plan comparison). See example from last year's response <http://www.catalyzepaymentreform.org/images/documents/NationalScorecard.pdf>.

The goal of this question is to establish the context as well as establish the denominators for other questions in this module. NOTE: This question asks about total dollars (\$) paid for PUBLIC as well as PRIVATE programs in calendar year (CY) 2014. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2014, Plans may elect to report on the most recent 12 months with sufficient information and note the time period in the detail box below. If this election is made, ALL answers on CPR payment dollar questions (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2 , 2.11.4 and 2.10.5) for CY 2014 should reflect the adjusted reporting period.

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial members, not including prescription drug costs.

- Commercial includes both self-funded and fully-insured business.

- Some of the questions, such as "Provide the total in-network dollars paid to providers for commercial members CY 2014," apply to multiple metrics and will inform multiple denominators. Accordingly, this question is only posed once but the answer will be used to calculate all relevant metrics.

NOTE that the TOTAL \$ in ROW 5 should be equal or close to the SUM of the dollars shown in column 3 (based on Row 1 column 1 4 for outpatient and hospital services (2.8.4 and 2.10.2)). Please explain the difference in detail box below if the number in column 1 is very different from the number displayed in column 3 in Row 5. (IF respondent also pays non-physicians which is not captured 2.8.4, the sum shown in column 3 would be less than 4 shown in column 1)

Detail Box: Note the 12 month time period used by respondent for all payment reform questions if time period is NOT the requested CY 2014. Also explain differences (IF ANY) in total \$ in row 5 columns 1 and 3.

	Total \$ Paid in Calendar Year (CY) 2014 or the most current 12 months with sufficient dollar information	Calculated percent Numerator = # in specific row Denominator for rows 1 to 5= Total in Row 6	Description of metric	Row Number
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for FULLY-INSURED commercial members	Decimal. From 0 to 100000000000.	For comparison. Unknown	Health Plan Dollars - Fully-Insured Commercial In-Network: Total in-network dollars paid to providers for fully-insured commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	1
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for SELF-INSURED commercial members	Decimal. From 0 to 100000000000.	For comparison. Unknown	Health Plan Dollars - Self-Funded Commercial In-Network: Total in-network dollars paid to providers for self-funded commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	2
Total OUT-OF-NETWORK dollars paid to ALL providers (including hospitals) for ALL (fully-insured and self-insured) commercial members	Decimal. From 0 to 100000000000.	For comparison. Unknown	Health Plan Dollars - Commercial Out-of-Network: Total out-of-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	3
Total dollars paid to ALL providers for public programs (involving non-commercial members)	Decimal. From 0 to 100000000000.	For comparison. Unknown	Health Plan Dollars - Public Programs: Total dollars paid to providers for public programs as a percent of total dollars paid to ALL providers for ALL lines of business	4
Calculated: Total IN-NETWORK dollars paid to ALL providers (including hospitals) for ALL commercial members.(sum of rows 1 and 2)	For comparison. 0	For comparison. Unknown	Health Plan Dollars - Total Commercial In-Network: Total in-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business. This is the denominator used for autocalc in rows 7 & 8	5

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			The sum of dollars reported for "all outpatient services" in Row 1 column 1 of 2.8.4 and "all hospital services" in Row 1 Column 1 of 2.10.2 is 0.	
Calculated: Total dollars paid to all providers for all lines of business (sum of rows 3, 4 and 5)	<i>For comparison.</i> 0	<i>For comparison.</i> Unknown	Denominator for rows 1 to 5	6
Provide the total IN-NETWORK COMMERCIAL dollars paid to ALL providers (including hospitals) through reference pricing. Reference pricing refers to an approach to pricing that establishes a health-plan determined covered amount (price) for a procedure, service or bundle of services, and generally requires that health plan participants pay any allowed charges beyond this amount. Common reference pricing programs are for commodity services such as labs, imaging, colonoscopies and other services where quality is thought not to vary. For the purpose of this question, reference pricing does not apply to prescription drugs. Include dollars paid even if this is a limited reference pricing pilot program.	<i>Decimal.</i> N/A OK. From 0 to 100000000000.	<i>For comparison.</i> Unknown	Steps to Payment Reform - Reference Pricing: Total dollars paid through reference pricing as percent of total commercial in-network dollars	7
Provide the total IN-NETWORK COMMERCIAL dollars paid to ALL providers (including hospitals) through value pricing. Value-pricing is defined similarly to reference pricing (see above) except that value-pricing is used for services where quality is thought to vary. Another distinction from reference pricing is that provider eligibility for participation in a value pricing program is dependent on meeting certain quality thresholds. Include dollars paid even if this is a limited value pricing pilot program. More information about reference and value pricing can be found at http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Price_Transparency.pdf .	<i>Decimal.</i> N/A OK. From 0 to 100000000000.	<i>For comparison.</i> Unknown	Steps to Payment Reform - Value-Based Pricing: Total dollars paid through reference pricing with quality components as percent of total commercial in-network dollars	8

8.2.3 Information to Physicians to Help Steer Members

8.2.3.1 How does the Plan 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

8.2.3.2 How does the Plan 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 plan selects response option #2 – plan needs to attach a sample of the targeted communication to the physician).

If Plan 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

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8.2.3.3 Please attach all communication materials and relevant screen prints from the online system to support Plan's response in 2.4.2 (above) as Provider 2.

Single, Pull-down list.

- 1: Provider 2 provided,
- 2: Not provided

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

Multi, Checkboxes.

- 1: Point of service physician decision support (e.g., reminders tagged to patients considering selected therapies like surgery for back pain, hysterectomy, bariatric surgery),
- 2: Routine reporting to physicians that identifies patient candidates for treatment decision support,
- 3: Patient communication aids (e.g., tear-off treatment tool referral),
- 4: None of the above services are used to help engage members in treatment decision support

8.2.3.5 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 Plan can track incidence of the procedures listed below and whether treatment decision support or member education are provided. Do not select member education unless the communication is specific to the Choosing Wisely procedure described (and not general information about the condition).

Choosing Wisely procedure	Plan activities	Rate/1000 members	Description of other
Imaging for low back pain within the first six weeks, unless red flags are present	Multi, Checkboxes. 1: Plan can report incidence of procedure, 2: Plan provides treatment decision support to member, 3: Plan provides member education about this procedure, 4: Other (describe), 5: None of the above	Decimal.	50 words.
Brain imaging studies (CT or MRI) in the evaluation of simple syncope and a normal neurological examination.	AS ABOVE	AS ABOVE	AS ABOVE
Repeat Abdominal CT for functional abdominal pain	AS ABOVE	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	AS ABOVE
Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms	AS ABOVE	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	AS ABOVE
Annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients	AS ABOVE	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	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	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	AS ABOVE

8.2.4 Physician Management and Support to Help Members Stay/Get Healthy

8.2.4.1 The CDC recommends that tobacco use be screened at every medical encounter. How does the plan monitor that clinicians screen adults for tobacco use at every provider visit?

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	Type of Monitoring	Detail
Screening adults for tobacco use at every medical encounter	<i>Multi, Checkboxes.</i> 1: Chart audit, 2: Electronic Medical Records, 3: Survey/Self report, 4: Other monitoring method (Describe in detail box), 5: This screening is recommended, but not monitored, 6: This screening is not recommended	65 words.

8.2.4.2 Identify Plan activities in calendar year 2014 for practitioner education and support related to tobacco cessation. 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 Provider 3. The following selections need documentation:

- 1: General communication to providers announcing resources/programs available for tobacco cessation (3a)
- 2: Comparative reporting (3b)
- 3: Member specific reminders to screen (3c)
- 4: Member specific reminders to treat (3d)

	Activities
Education/Information	<i>Multi, Checkboxes.</i> 1: General education of guidelines and health plan program offerings, 2: Notification of member identification, 3: CME credit for smoking cessation education, 4: Comparative performance reports (identification, referral, quit rates, etc.), 5: Promotion of the appropriate smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 99402, and HCPCS G0375, G0376) (describe), 6: None of the above
Patient Support	<i>Multi, Checkboxes.</i> 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	<i>Multi, Checkboxes.</i> 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Plan 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	<i>Multi, Checkboxes.</i> 1: The plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports), 5: Care plan approval, 6: None of the above
Description	200 words.

8.2.4.3 If plan selected response options 1 and 4 in education/information and options 2 and 3 in patient support in question above, provide evidence of practitioner support as Provider 3. 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 (3a),
- 2: Comparative reporting (3b),
- 3: Member specific reminders to screen (3c),
- 4: Member specific reminders to treat (3d),
- 5: Provider 3 not provided

8.2.4.4 Identify Plan activities in calendar year 2014 for practitioner education and support related to obesity management. Check all that apply. If any of the following four (4) activities are selected, documentation must be provided as Provider 4 in the following question:

- 1: Member-specific reports or reminders to treat (4a)
- 2: Periodic member program reports (4b)
- 3: Comparative performance reports (4c) and
- 4: General communication to providers announcing resources/programs available for weight management services (4d)

	Activities
Education/Information	<i>Multi, Checkboxes.</i> 1: General education of guidelines and health plan program offerings, 2: Educate providers about screening for obesity in children, 3: Notification of member identification, 4: CME credit for obesity management education, 5: Comparative performance reports (identification, referral, quit rates, etc.),

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	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: Plan 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 plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports), 5: Care plan approval, 6: None of the above
Description	200 words.

8.2.4.5 Provide evidence of the practitioner support that is member or performance specific selected above as Provider 4.

Multi, Checkboxes.

- 1: Member-specific reports or reminders to treat (4a),
- 2: Periodic member program reports (4b),
- 3: Comparative performance (4c) reports,
- 4: General communication to providers announcing resources/programs available for weight management services (4d),
- 5: Provider 4 is not provided

8.2.5 Scope of Physician Measurement for Transparency and Rewards

8.2.5.1 Purchasers expect that health plans 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: Plan is not in compliance with the Patient Charter,
- 2: Plan is in compliance with some/all of the following elements of the Patient Charter: [Multi, Checkboxes],
- 3: Plan uses own criteria [200 words],
- 4: Plan meets the measurement criteria specified in the NCQA PHQ standards,
- 5: Plan does not meet the NCQA PHQ standards

8.2.5.2 If plan is measuring and reporting on physician performance, provide information in table below on network physicians that are being measured and reported on. Use the same time 12 month period as was used in (2.2.4, 2.7.2, 2.8.4, 2.8.6, 2.11.2, 2.10.2, 2.11.4 and 2.10.5)

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 commercial book of business	Response	Autocalculation
Total number of PCP physicians in network	Decimal.	
Total number of PCP physicians in network for whom the measurement results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	Decimal. N/A OK. From 0 to 1000000000.	For comparison. 0.00%
Total \$ value of claims paid to all PCP physicians in network	Dollars.	
Total \$ value of claims paid to those PCP physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	Dollars. N/A OK. From 0 to 100000000000.	For comparison. 0.00%
Total number of Specialty physicians in network	Decimal.	

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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%

8.2.6 Physician Payment Programs for Value Achievement (Quality and/or Efficiency)

8.2.6.1 Purchasers are under significant pressure to address the dual goals of ensuring employees 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 entire commercial book of 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. **Please refer to response in question 2.8.4 and the attached definitions document.**

If there is more than one payment reform program involving outpatient services, please provide descriptions in the additional columns

If plan 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 plan to implement in market of response within the next 6 months.

In addition to being summarized for site visits, answers to this question will be also used to populate Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which is an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform is a publicly available valuable resource for researchers, policymakers, journalists, plans and employers to highlight innovative health plan or program entity programs. To view the live Compendium website, please [click here](#). If you do not want this information to be used in the Compendium, please opt-out by checking the box in the last response row.

This question replaces 3.4.1 and section 3.10 from eValue8 2012.

	Program 1	Other markets/details for Program 1	Repeat for Programs 2-5	Row Number
Name of Payment Reform Program	65 words.	N/A	N/A	1
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	5 words.	N/A	N/A	2
Contact Person's Title	5 words.	N/A	N/A	3
Contact Person's Email	5 words.	N/A	N/A	4
Contact Person's Phone	5 words.	N/A	N/A	5
Contact Name for person who is authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact name for the payment reform program, please reenter his/her name)	5 words.	N/A	N/A	6
Email for person authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact email)	5 words.	N/A	N/A	7

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for the payment reform program, please reenter his/her email)				
Geography of named payment reform program (Ctrl-Click for multiple states)	<i>Single, Radio group.</i> 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	<i>Multi, List box.</i> 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc. (all states)		8
Summary/Brief description of Program (500 words or less)	<i>500 words.</i>	N/A		9
Identify the line(s) of business for which this program is available?	<i>Multi, Checkboxes.</i> 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	<i>50 words.</i>		10
What is current stage of implementation? Provide date of implementation in detail column	<i>Single, Radio group.</i> 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)	<i>To the day.</i>		11
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.	<i>Single, Radio group.</i> 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)	<i>65 words.</i>		12
Which base payment methodology does your program use?	<i>Single, Radio group.</i> 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)	<i>50 words.</i>		13
What types of providers are participating in your program?	<i>Multi, Checkboxes.</i> 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)	<i>50 words.</i>		14
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?	<i>Multi, Checkboxes.</i> 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)	<i>65 words.</i>	<i>65 words.</i>	15
Which of the following sets of performance measures does your program use?	<i>Multi, Checkboxes.</i> 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)	<i>50 words.</i>	<i>50 words.</i>	16
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to support the payment reform program.	<i>Multi, Checkboxes.</i> 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,	<i>50 words.</i>	<i>50 words.</i>	17

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	providing evidence of higher-quality care rendered by these providers, 6: No active steering, 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?	<i>Multi, Checkboxes.</i> 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.	50 words.	18
Describe evaluation and results for program	<i>Multi, Checkboxes.</i> 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.	100 words.	19
Do not include this information in the National Compendium on Payment Reform	<i>Multi, Checkboxes - optional.</i> 1: X			20

8.2.6.2 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. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars). Please see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>

Denominator (preferred): all PCPs in network and relevant specialists in network that would treat the condition

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in 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 plan 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_12-31-2004.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	<i>Multi, Checkboxes.</i> 1: Individual Physician, 2: Practice Site, 3: Medical Group/PA/Staff model Group, 4: PCMH, 5: ACO, 6: Other (describe), 7: None of the above	<i>Multi, Checkboxes.</i> 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			

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Coronary Artery Bypass Graft	AS ABOVE	AS ABOVE			
Perioperative Care	AS ABOVE	AS ABOVE			
Back pain	AS ABOVE	AS ABOVE			
Coronary Artery Disease	AS ABOVE	AS ABOVE			
Heart Failure	AS ABOVE	AS ABOVE			
Community-Acquired Pneumonia	AS ABOVE	AS ABOVE			
Asthma	AS ABOVE	AS ABOVE			
NCQA Recognition program certification	AS ABOVE	AS ABOVE			
Patient experience survey data (e.g., A-CAHPS)	AS ABOVE	AS ABOVE			
Mortality or complication rates where applicable	AS ABOVE	AS ABOVE			
Efficiency (resource use not unit cost)	AS ABOVE	AS ABOVE			
Pharmacy management (e.g. generic use rate, formulary compliance)	AS ABOVE	AS ABOVE			
Medication Safety	AS ABOVE	AS ABOVE			
Health IT adoption/use	AS ABOVE	AS ABOVE			
Preventable Readmissions	AS ABOVE	AS ABOVE			
Preventable ED/ER visits (NYU)	AS ABOVE	AS ABOVE			

8.2.6.3 PPO version of above

8.2.6.4 This and questions 2.8.6 and 2.10.2 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) and replaces 3.5.3 and 3.5.4 from eValue8 2012. **The corresponding question for hospital services is 2.10.2. THE SUM of the Number in Row 1 column 1 for outpatient and hospital services (2.8.4 and 2.10.2) should EQUAL ROW 5 in Question 2.2.4 above**

Please count OB-GYNs as specialty care physicians. Please refer to the attached definitions document.

NOTE: This question asks about total \$ paid in calendar year (CY) 2014. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2014, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2, 2.11.4 and 2.10.5) for CY 2014 should reflect the adjusted reporting period.

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial 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.

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3. Identify the **dominant** payment reform mechanism for a given payment reform program.
4. For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program (e.g., if your program pays providers based upon thresholds for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).

NOTE: Plan should report **ALL** dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.

ALL 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 Calendar Year (CY) 2014 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	Row Number
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%	1
Provide the total dollars paid to providers through traditional FFS payments in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	2
Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	3
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	4
Provide the total dollars paid to providers through fully capitated programs without quality in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	5
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2014 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]	For comparison. \$0.00	Percent.	Percent.	Percent.	AS ABOVE	AS ABOVE	6

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Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	7
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	8
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	9
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	10
Provide the total dollars paid to providers through fully capitated payment with quality components in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	11
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	12
Provide the total dollars paid to providers through bundled payment programs with quality components CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	13
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	14
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	15
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	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	16
Total dollars paid to payment reform programs based on FFS.	<i>For comparison.</i> \$0.00	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	AS ABOVE	AS ABOVE	17

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Total dollars paid to payment reform programs NOT based on FFS.	<i>For comparison.</i> \$0.00	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	AS ABOVE	AS ABOVE	18
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8.2.6.5 Please review your responses to question 2.8.4 above. On an aggregate basis for the plan's book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for outpatient services (no associated hospital charges), and which payment approaches, if any, the health plan is using currently to tie payment to performance. If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not used.

	Estimate of allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other
Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)	<i>Percent.</i>	<i>Single, Pull-down list.</i> 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	<i>Multi, Checkboxes.</i> 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)	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Improvement over time of NQF-endorsed Outcomes and/or Process measures	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Longitudinal efficiency relative to target or peers	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
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)	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Patient experience	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Health IT adoption or use	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Financial results	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Utilization results	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.
Pharmacy management	<i>Percent.</i>	AS ABOVE	AS ABOVE	65 words.

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Other	Percent.	AS ABOVE	AS ABOVE	65 words.
TOTAL	Percent.	AS ABOVE	AS ABOVE	65 words.

8.2.6.6 For some of the information provided in 2.8.4 above, 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 plan response in 2.8.4

OUTPATIENT SERVICES	ALL Providers for Outpatient Services Total \$ Paid in Calendar Year (CY) 2014 or most current 12 months (autopopulated from 2.8.4)	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) [autopopulated from row 1 column 1 in 2.8.4]	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 CY 2014 for outpatient services [autopopulated from row 6 column 1 in 2.8.4]	0	Percent. N/A OK.	Percent. N/A OK.
Total dollars paid to payment reform programs based on FFS. [autopopulated from row 17 column 1 in 2.8.4]	0	Percent. N/A OK.	Percent. N/A OK.
Total dollars paid to payment reform programs NOT based on FFS. [autopopulated from row 18 column 1 in 2.8.4]	0	Percent. N/A OK.	Percent. N/A OK.

8.2.7 Plan Policies on Healthcare Acquired Conditions and Never Events

8.2.7.1 Please indicate the scope AND REACH of the policy to address serious reportable events (SREs) or healthcare acquired conditions (HACs) also known as hospital-acquired conditions based on the following categories of services. **Policy must be in place as of February 28, 2015.**

Leapfrog Never Event policy can be found at: http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/never_events

	Response	% contracted Hospitals where Plan has implemented this POLICY as of 2/28/2015
Foreign object retained after surgery	<i>Single, Pull-down list.</i> 1: Plan has implemented Leapfrog Never Event Policy. 2: Plan has implemented a non-payment policy, 3: Plan does not have a policy/POA not tracked	Percent. N/A OK. From 0 to 100.
Air embolism	AS ABOVE	AS ABOVE
Blood incompatibility	AS ABOVE	AS ABOVE
Stage III and IV pressure ulcers	AS ABOVE	AS ABOVE
Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)	AS ABOVE	AS ABOVE

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Catheter-Associated Urinary Tract Infection (UTI)	AS ABOVE	AS ABOVE
Vascular Catheter-Associate Infection	AS ABOVE	AS ABOVE
Manifestations of Poor Glycemic Control	AS ABOVE	AS ABOVE
Surgical Site Infection following Coronary Artery Bypass Graft (CABG) - -Mediastinitis	AS ABOVE	AS ABOVE
Surgical Site Infection Following Certain Orthopedic Procedures	AS ABOVE	AS ABOVE
Surgical Site Infection Following Bariatric Surgery for Obesity	AS ABOVE	AS ABOVE
Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures	AS ABOVE	AS ABOVE

8.2.7.2 For total commercial book of business, if the Plan indicated in Questions above (2.9.1 to 2.9.5) that it does not pay for Healthcare Acquired Conditions (HACs) also known as hospital-acquired conditions or for **Serious Reportable Events (SRE) that are not HACs**, indicate if the policy applies to the following types of reimbursement. For hospital contracts where the payment is not DRG-based, briefly describe in the Detail box below the mechanisms the Plan uses to administer non-payment policies? Also discuss how payment and member out-of-pocket liability is handled if the follow-up care or corrective surgery occurs at a different facility than where the HAC or SRE occurred.

	Insured Program	Self-Funded Program
% of charges	Multi, Checkboxes. 1: Normal contracted payment applies, 2: Proportional reduction of total contractual allowance, 3: Reduced patient out-of-pocket payment, 4: Cost excluded from employers' claims experience, 5: Other (describe in Detail below)	Multi, Checkboxes. 1: Normal contracted payment applies, 2: Proportional reduction of total contractual allowance, 3: Reduced patient out-of-pocket payment, 4: Cost excluded from employers' claims experience, 5: Other (describe in Detail below)
Capitation	AS ABOVE	AS ABOVE
Case Rates	AS ABOVE	AS ABOVE
Per Diem	AS ABOVE	AS ABOVE
DRG	AS ABOVE	AS ABOVE

8.2.8 Hospital Payment Programs for Value Achievement

8.2.8.1 Purchasers are under significant pressure to address the dual goals of ensuring employees 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 response in question 2.10.2 and 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 plan 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 plan to implement in market of response within the next 6 months.

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In addition to being summarized for site visits, answers to this question will be also used to populate Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which is an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform is a publicly available valuable resource for researchers, policymakers, journalists, plans and employers to highlight innovative health plan or program entity programs. To view the live Compendium website, please [click here](#). If you do not want this information to be used in the Compendium, please opt-out by checking the box in the last response row.

This question replaces 3.6.1 and section 3.10 from eValue8 2012.

	Program 1	Other markets/details for Program 1	Repeat for Programs 2-5	Row Number
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	N/A	1
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	5 words.	N/A	N/A	2
Contact Person's Title	5 words.	N/A	N/A	3
Contact Person's Email	5 words.	N/A	N/A	4
Contact Person's Phone	5 words.	N/A	N/A	5
Contact Name for person who is authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact name for the payment reform program, please reenter his/her name)	5 words.	N/A	N/A	6
Email for person authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact email for the payment reform program, please reenter his/her email)	5 words.	N/A	N/A	7
Geography of named payment reform program (Ctrl-Click for multiple states)	<i>Single, Radio group.</i> 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	<i>Multi, List box.</i> 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc., all states	<i>Multi, List box.</i> 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc., all states	8
Summary/Brief description of Program (500 words or less)	500 words.	N/A	N/A	9
Identify the line(s) of business for which this program is available?	<i>Multi, Checkboxes.</i> 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	50 words.	50 words.	10
What is current stage of implementation? Provide date of implementation in detail column	<i>Single, Radio group.</i> 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 the day.	11
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.	<i>Single, Radio group.</i> 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.	65 words.	12

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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.	50 words.	13
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.	50 words.	14
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.	65 words.	15
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.	50 words.	16
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.	50 words.	17
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.	50 words.	18
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.	100 words.	19
Do not include this information in the National Compendium on Payment Reform	Multi, Checkboxes - optional. 1: X			20

8.2.8.2 This and questions 2.8.4 and 2.8.6 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 and replaces 3.8.1 and 3.8.2 from

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eValue8 2012. The corresponding question for outpatient services is 2.8.4. The SUM of the Number in Row 1 column 1 for outpatient and hospital services (2.8.4 and 2.10.2) should EQUAL ROW 5 in Question 2.2.4.

Please refer to the attached definitions document.

NOTE: This question asks about total \$ paid in calendar year (CY) 2014. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2014, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2, 2.11.4 and 2.10.5) for CY 2014 should reflect the adjusted reporting period.

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial 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: Plan should report ALL dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.

HOSPITAL SERVICES	ALL Providers for HOSPITAL Services Total \$ Paid in Calendar Year (CY) 2014 or most current 12 months Estimate breakout of amount in this column into percentage by contracted entity paid in next 2 columns	HOSPITALS paid under listed payment category below Estimated Percentage of dollar amount listed in column 1 for each row	Contracted entities (e.g., ACOs/PCMH/Medical Groups/IPAs) paid under listed payment category below Estimated Percentage of dollar amount listed in column 1 for each row	This column activated only if there is % listed in column 3 Please select which contracted entities are paid in column 3	Autocalculated percent based on responses in column 1. Denominator = total \$ in row 1 column 1 Numerator = \$ in specific row C1	Row Number
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%	1
Provide the total dollars paid to providers through traditional FFS payments in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	2
Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	3
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2014 or most recent 12 months	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	4
Provide the total dollars paid to providers through fully capitated programs without	Dollars. N/A OK.	Percent. N/A OK.	Percent. N/A OK.	AS ABOVE	AS ABOVE	5

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quality in CY 2014 or most recent 12 months						
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2014 for hospital services [Sum of Rows 2, 3 4 and 5]	<i>For comparison.</i> \$0.00	<i>Percent.</i>	<i>Percent.</i>	AS ABOVE	AS ABOVE	6
Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	7
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	8
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	9
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	10
Provide the total dollars paid to providers through fully capitated payment with quality components in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	11
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	12
Provide the total dollars paid to providers through bundled payment programs with quality components CY 2014 or most recent 12 months	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	13
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	14
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in CY 2014 or most recent 12 months.	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	15
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	<i>Dollars.</i> N/A OK. From 0 to 10000000000000000.	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.	AS ABOVE	AS ABOVE	16
Total dollars paid to payment reform programs based on FFS. AUTOSUM ROWS 8, 10 and 14	<i>For comparison.</i> \$0.00	<i>Percent.</i>	<i>Percent.</i>	AS ABOVE	AS ABOVE	17
Total dollars paid to payment reform programs NOT based on FFS. AUTOSUM ROWS 7, 9, 11-13, 15 and 16	<i>For comparison.</i> \$0.00	<i>Percent.</i>	<i>Percent.</i>	AS ABOVE	AS ABOVE	18

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8.2.8.3 Please review your responses to question 2.10.2 above. On an aggregate basis for the plan's **total commercial** book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for hospital services, and which payment approaches, if any, the health plan is using currently to tie payment to performance. If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not use. (This question replaces 3.8.6 from eValue8 2012 and uses same measures as in 2.8.5).

Hospital Services	Estimate of Allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other	Row Number
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.	1
Achievement (relative to target or peers) of Clinical outcomes goals (e.g., readmission rate, mortality rate, A1c, cholesterol values under control)	Percent.	AS ABOVE	AS ABOVE	65 words.	2
Improvement over time of NQF-endorsed Outcomes and/or Process measures	Percent.	AS ABOVE	AS ABOVE	65 words.	3
PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	Percent.	AS ABOVE	AS ABOVE	65 words.	4
Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	Percent.	AS ABOVE	AS ABOVE	65 words.	5
Longitudinal efficiency relative to target or peers	Percent.	AS ABOVE	AS ABOVE	65 words.	6
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)	Percent.	AS ABOVE	AS ABOVE	65 words.	7
Patient experience	Percent.	AS ABOVE	AS ABOVE	65 words.	8
Health IT adoption or use	Percent.	AS ABOVE	AS ABOVE	65 words.	9
Financial results	Percent.	AS ABOVE	AS ABOVE	65 words.	10
Utilization results	Percent.	AS ABOVE	AS ABOVE	65 words.	11
Pharmacy Management	Percent.	AS ABOVE	AS ABOVE	65 words.	12
Other	Percent.	AS ABOVE	AS ABOVE	65 words.	13
Total	Percent.	AS ABOVE	AS ABOVE	65 words.	14

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8.2.8.4 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 receiving payment reward. To calculate percentage, please use unduplicated count of hospitals and physicians. This is same measure set as in 4.6.2

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_12-31-2004.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbqh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_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: 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

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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
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
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

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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

8.2.8.5 Payment Reform for High Volume/High Spend Conditions - Maternity Care Services (Note: Metrics below apply only to in-network dollars paid for commercial members).

Please go to question 5.3.7 in Maternity ensure your response in 5.3.7 is consistent with your response to this question.

EXAMPLE ASSUMING A HEALTH PLAN CONTRACTS WITH ONLY TWO HOSPITALS (FOR ILLUSTRATION PURPOSES):

Hospital A has a contract that includes a financial incentive or disincentive to adhere to clinical guidelines for maternity care. The maternity care financial incentive or disincentive may be part of a broader quality incentive contract, such as a P4P program for the hospital where a portion of the bonus pay is tied to performance for delivering clinically safe and appropriate maternity care. The total dollars paid to Hospital A for maternity care was \$100 (reported in row 1). Because there is a maternity care financial or disincentive incentive in the contract for Hospital A, \$100 is also reported in row 2.

Hospital B does **not** have a contract where there is a financial incentive or disincentive to adhere to clinical guidelines for maternity care. The total dollars paid to Hospital B for maternity care is \$100 (reported in row 1). However, since Hospital B does NOT have a maternity care financial incentive or disincentive in the contract, \$0 is reported on row 2.

Two hundred dollars (\$200), the sum of the total dollars paid for maternity care for Hospitals A and B, would be reported in line 1. In row 2, only \$100 is reported, as only one of the hospitals has a contract with a financial incentive or disincentive for maternity care services.

If BOTH Hospitals A and B have contracts with financial incentives or disincentives for adhering to clinical guidelines for maternity care, then the total for row 2 is \$200. The second row is NOT asking for the specific dollars that are paid for the maternity care financial incentive component of the contract.

Use the process described above for all contracts with hospitals for maternity care to provide a complete numerator and denominator for this question.

Maternity Services Payment Reform	Response
Provide the total dollars paid to hospitals for maternity care in Calendar Year (CY) 2014 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

8.2.9 Plan Steerage of Members to Centers of Excellence and Higher Value Physicians and Hospitals

8.2.9.1 If the Plan 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.

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	Primary care	Specialty care
Tiered networks, PCMH or ACOs not used	<i>Multi, Checkboxes - optional.</i> 1: Not used	<i>Multi, Checkboxes - optional.</i> 1: Not used
Number of physicians in full product network	<i>Decimal.</i> N/A OK. From 0 to 10000000000.	<i>Decimal.</i> 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	<i>For comparison.</i> N/A%	<i>For comparison.</i> N/A%
Number of physicians in PCMH only (exclude those in ACOs)	<i>Decimal.</i> N/A OK. From 0 to 10000000000.	<i>Decimal.</i> N/A OK. From 0 to 10000000000.
Percent of network physicians in PCMH	<i>For comparison.</i> N/A%	<i>For comparison.</i> N/A%
Number of physicians in ACOs	<i>Decimal.</i> N/A OK. From 0 to 10000000000.	<i>Decimal.</i> N/A OK. From 0 to 10000000000.
Percent of network physicians in ACOs	<i>For comparison.</i> N/A%	<i>For comparison.</i> N/A%
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (most recent 12 months)	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> 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)	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.
Percent of total physician payments made to PCMHs (not to those in ACOs) (most recent 12 months)	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK. From 0 to 100.
Percent of total physician payments made to physicians in the ACO (most recent 12 months)	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK. From 0 to 100.
Design incentives - HMO	<i>Multi, Checkboxes.</i> 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable	<i>Multi, Checkboxes.</i> 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable
Design incentives - PPO	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 in calendar year 2014. 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.

8.2.9.2 Payment Reform Penetration - Plan Members: For those providers that participated in a payment reform contract in CY 2014 (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 Commercial (self-funded and fully-insured) lives only. It does not include Medicare Advantage or Medicaid beneficiaries.

	Regional Response	Autocalc Percent	Statewide Response	Autocalc Percent
Total number of commercial, in-network health plan members attributed to a provider with a payment reform program contract	<i>Decimal.</i>	Unknown	<i>Decimal.</i>	Unknown
Total number of commercial, in-network health plan members attributed to ACOs	<i>Decimal.</i>	Unknown	<i>Decimal.</i>	Unknown

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Total number of commercial, in-network health plan members attributed to PCMHs (for PCMH not part of ACO)	<i>Decimal.</i>	Unknown	<i>Decimal.</i>	Unknown
Enrollment of TOTAL commercial enrollment	0	100%	0	100%

8.2.9.3 For commercial book of business, provide the requested information on the Plans in-network general acute care hospitals in the geographic region of this RFI response based on reports to the Leapfrog survey in 2012 and 2013. Multi-market plans should provide their statewide response in the column "For multimarket plans, and also indicate 2013 statewide percentages."

The 2013 "Leapfrog's Health Plan Performance Dashboard," shows what percentage of a plan's admissions have been at hospitals that report to Leapfrog and what percentage of their admission use hospitals that score in the highest "quadrant" based on both their quality and resource use scores.

Use this link for the 2013 HPUG dashboard: www.leapfroggroup.org/healthplanusersgroup

For 2012 data, plans should use what they submitted last year. Plans who did not respond last year should select the NA box.

Additionally, the link below shows how all of the measures are displayed:

http://www.leapfroggroup.org/cp?frmbmd=cp_listings&find_by=city&city=boston&state=MA&cols=oa

	2013	For multimarket plans, also indicate 2013 statewide percentages	2012
Percent of contracted hospitals reporting in this region	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.
Percent of Plan admissions to hospitals reporting to Leapfrog	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.
Leapfrog Performance Dashboard % admissions in Quadrant I	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.
Leapfrog Performance Dashboard % admissions in Quadrant III	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.

8.2.9.4 For total commercial book of business, if the Plan differentiates its contracted hospitals 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.

	Hospitals
Tiered networks/ACOs used	<i>Single, Radio group.</i> 1: Yes, 2: No
Number of hospitals in full product network	<i>Decimal.</i> From 0 to 10000000000.
Number of network hospitals in preferred tier/narrow network (not in ACO)	<i>Decimal.</i> N/A OK. From 0 to 10000000000.
Number of network hospitals in ACOs	<i>Decimal.</i> N/A OK. From 0 to 10000000000.
Percent of network hospitals in preferred tier/narrow network (not in ACO)	Unknown
Percent of network hospitals in ACOs	Unknown
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (most recent 12 months)	<i>Percent.</i> N/A OK. From 0 to 100.
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (prior 12 months)	<i>Percent.</i> N/A OK. From 0 to 100.

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Percent of total hospital payments made to hospitals in ACOs (most recent 12 months)	Percent. N/A OK. From 0 to 100.
Design Incentives (HMO)	Multi, Checkboxes. 1: differential copay, 2: differential coinsurance, 3: differential deductible, 4: lower premium (narrow network), 5: none of the above
Design Incentives (PPO)	Multi, Checkboxes. 1: differential copay, 2: differential coinsurance, 3: differential deductible, 4: lower premium (narrow network), 5: none of the above
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing hospitals in calendar year 2014. This could include (1) reduction in costs, (2) change in amount paid to higher performing hospitals or (3) change in percent of membership using higher performing hospitals	100 words.

8.2.9.5 For HMO, indicate how members are steered toward COE facilities. For steerage results indicate % of targeted services to designated facilities. Describe any measured quality impact such as reduced complications or improved outcomes, as well as any savings impact such as reduced length of stay.

HMO response	Selection Criteria	Steerage Results 2014	Quality and Cost Impact (2014)	Steerage Results 2013
Bariatric Surgery	Multi, Checkboxes. 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	Percent. N/A OK.	Unlimited.	Percent. N/A OK.
Cancer Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Cardiac Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Neonatal Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Transplants	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.2.9.6 PPO version of question.

8.2.10 Hospital Management Performance

8.2.10.1 Reducing readmissions is an area of great interest to purchasers and payers as it impacts employee/member 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 review the following information based on plan HMO submission to NCQA.

This answer is supplied by Health Benefit Exchange (individually).

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

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55-64 Total	<i>Percent.</i> From -5 to 100.	<i>Decimal.</i> From -5 to 1.	N/A
Total Total	<i>Percent.</i> From -5 to 100.	<i>Decimal.</i> From -5 to 1.	<i>Decimal.</i> From -10 to 100.

8.2.10.2 PPO version of question

8.2.11 Other Information

8.2.11.1 If the plan would like to provide additional information about its approach to Provider Measurement that was not reflected in this section, provide as Provider 7. Is Provider 7 attached?

Single, Pull-down list.
1: Yes with a 4 page limit,
2: No

8.3 HELPING MEMBERS STAY/GET HEALTHY

8.3.1 Instructions

8.3.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.

8.3.1.2 All attachments to this module must be labeled as "Healthy #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Healthy 1a, 1b, etc.

8.3.1.3 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been auto-populated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

8.3.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

8.3.2 Alignment of Plan Design

8.3.2.1 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for **preventive or wellness services** by any of the means listed in the "Financial incentives" column? In the "Uptake" column, **estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes)**. In the "Product Availability" column, indicate the plan product types in which the incentive feature is available. Check all that apply. a. Account-based means consumer-directed health plan with a health reimbursement account or a high deductible health plan with a health savings account b. For "Product availability" column, Plan should select all platforms on which the indicated financial incentives are in place.

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

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

Please respond accordingly in the last column.

HMO Response - Preventive and Wellness Services	Financial Incentives	Product availability	Uptake as % of total commercial statewide membership noted in 1.3.3	Percentage is based on plan's entire commercial membership in all markets of plan operation
A: Incentives contingent upon member behavior				

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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	Multi, Checkboxes. 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	Percent. N/A OK. From 0 to 100.	Yes/No.
Participation in other Plan-designated high performance practices	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Personal Health Assessment (PHA)	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	AS ABOVE	AS ABOVE	Yes/No.
Participation in weight-loss program (exercise and/or diet/nutrition)	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Success in weight-loss or maintenance	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Participation in tobacco cessation	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Success with tobacco cessation goals	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Participation in wellness health coaching	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Success with wellness goals other than weight-loss and tobacco cessation	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
B: Incentives not contingent on participation or completion				
Well child & adolescent care	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.
Preventive care (e.g. cancer screening, immunizations)	AS ABOVE	AS ABOVE	AS ABOVE	Yes/No.

8.3.2.2 PPO version of question above.

8.3.3 Health Assessments (HA)

8.3.3.1 Indicate activities and capabilities supporting the plan's 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.,

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- 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: Plan can import data from employer-contracted HA vendor.,
 15: Plan does not offer an HA

8.3.3.2 Provide the number of currently enrolled members who completed a Health Assessment (HA), (formerly known as Health Risk Assessment - HRA or PHA- Personal Health Assessment) in the past year. **Please provide state or regional counts if available.** If regional/state counts are not available, provide national counts.

If the Plan has partnered with employers to import data from an employer-contracted PHA vendor, enter a number in the fifth row. (see also question 3.3.1 and 3.3.2)

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, including this state/region (and this state/region response provided below), 2: Participation tracked statewide and for some regions but not this region/state (and statewide response provided below), 3: Participation only tracked statewide (statewide data provided below), 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at individual employer 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)	For comparison. TBD
Number of members completing Plan-based PHA in 2014 for regional or statewide geography as checked above.	Decimal. From 0 to 1000000000000000000.
Number of members completing an employer-based vendor PHA in 2014, for regional or statewide geography as checked above.	Decimal. N/A OK. From 0 to 100000000000.
Percent PHA completion regionally or statewide as indicated above (Plan PHA completion number + employer PHA completion number divided by total enrollment)	For comparison. Unknown

8.3.3.3 PPO version of question above.

8.3.3.4 Identify methods for promoting Health Assessment (HA) (formerly known as Health Risk Assessment – HRA, or PHA- Personal Health Assessment) completion to 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 Plan website or member newsletter	Multi, Checkboxes. 1: 1-2 X per year, 2: 3-6 X per year, 3: > 6 X per year, 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results. This was formerly referred to as Health Risk Assessment (HRA).	Single, Radio group. 1: Yes, 2: No	100 words. Nothing required
Financial incentives from Plan to members (describe): (FOR FULLY INSURED PRODUCTS ONLY)	Single, Radio group. 1: Yes, 2: No, 3: Not applicable	100 words. Nothing required

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Financial incentives from Plan to employers (describe): (FOR FULLY INSURED PRODUCTS ONLY)	<i>Single, Radio group.</i> 1: Yes, 2: No, 3: Not applicable	100 words. Nothing required
Promoting use of incentives and working with Purchasers to implement financial incentives for employees (describe):	<i>Single, Radio group.</i> 1: Yes, 2: No, 3: Not applicable	100 words. Nothing required
Multiple links (3 or more access opportunities) to HA within Plan website (indicate the number of unique links to the HA). Documentation needed, provide in 3.3.7	<i>Decimal.</i> N/A OK. From 0 to 100000000000000000.	
Promotion through provider (describe):	<i>Single, Radio group.</i> 1: Yes, 2: No	100 words. Nothing required
Promotion through health coaches or case managers (describe):	<i>Single, Radio group.</i> 1: Yes, 2: No	100 words. Nothing required

8.3.3.5 PPO version of question above.

8.3.3.6 If Plan indicated above that HAs are promoted through multiple links on their website, provide documentation for three web access points as Healthy 1. Only documentation of links will be considered by the reviewer. The link should be clearly identified and if not evident, the source of the link, e.g. home page, doctor chooser page, etc., may be delineated.

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

8.3.3.7 Indicate manner in which Plan does support or can support administration of employer-sponsored incentives. Check all that apply.

HMO Response	Response	Fee Assessment
Communicate employer incentive plan to members on behalf of employer	<i>Multi, Checkboxes.</i> 1: Currently in place for at least one employer, 2: Plan can/will undertake when requested, 3: Plan will not perform this function	<i>Single, Pull-down list.</i> 1: Fee routinely assessed, 2: No fee applies, 3: Fee may or may not be assessed based on circumstances or contract
Report HA participation to employer	AS ABOVE	AS ABOVE
Report aggregate HA results to employer for purposes of developing wellness programs	AS ABOVE	AS ABOVE
Based on HA results, recommend to member disease management or wellness program participation required for receipt of incentive	AS ABOVE	AS ABOVE
Track and report member participation in recommended DM or wellness programs to employer	AS ABOVE	AS ABOVE
Track and report outcome metrics (BMI, tobacco cessation) to employer	AS ABOVE	AS ABOVE
Fulfill financial incentives based on employer instruction	AS ABOVE	AS ABOVE
Fulfill non-financial incentives based on employer instruction	AS ABOVE	AS ABOVE

8.3.3.8 PPO version of above.

8.3.4 Cancer Screening Programs and Results

8.3.4.1 Review the two most recently calculated years of HEDIS results for the HMO Plan (QC 2014 and 2013). The HEDIS measure eligible for rotation for QC 2014 is Colorectal Cancer Screening.

If plan rotated Colorectal Cancer Screening in QC 2014, QC 2014 would be based on QC 2013, so the prior year data that would be uploaded would be QC 2012.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

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

This answer is supplied by Health Benefit Exchange (individually).

	QC 2014	QC 2013, or prior year's HMO QC result
Breast Cancer Screening - Total	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Cervical Cancer Screening	AS ABOVE	AS ABOVE
Colorectal Cancer Screening (Eligible for rotation in QC 2014)	AS ABOVE	AS ABOVE

8.3.4.2 PPO version of above.

8.3.4.3 Which of the following member interventions applying to at least 75% of your enrolled membership were used by the Plan in calendar year 2014 to improve cancer screening rates? Indicate all that apply.

	Educational messages identifying screening options discussing risks and benefits	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Breast Cancer Screening	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Single, Radio group.</i> 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	<i>Single, Radio group.</i> 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available
Cervical Cancer Screening	AS ABOVE	AS ABOVE	AS ABOVE
Colorectal Cancer Screening	AS ABOVE	AS ABOVE	AS ABOVE

8.3.4.4 Provide copies of all member-specific interventions described in Question 3.4.3 as Healthy 2. Reviewer will be looking for evidence of member specificity and indication that service is due, if applicable. Note: if the documentation does not specify that a service is needed, then indicate on the attachment how the reminder is based on missed services vs. a general reminder. Do NOT send more examples than is necessary to demonstrate functionality.

Multi, Checkboxes.

- 1: Healthy 2a is provided - Breast Cancer Screening,
- 2: Healthy 2b is provided - Cervical Cancer Screening,
- 3: Healthy 2c is provided - Colorectal Cancer Screening,
- 4: No attachments provided

8.3.5 Immunization Programs

8.3.5.1 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2014 and QC 2013) results for the HMO Plan.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

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

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This answer is supplied by Health Benefit Exchange (individually).

	QC 2014, or most current year's HMO result	QC 2013, or prior year's HMO QC result
Childhood Immunization Status - Combo 2	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Immunizations for Adolescents - Combination	AS ABOVE	AS ABOVE
CAHPS Flu Shots for Adults (50-64) (report rolling average)	AS ABOVE	AS ABOVE

8.3.5.2 PPO version of above.

8.3.5.3 Identify member interventions used in calendar year 2014 to improve immunization rates. Check all that apply.

	Response	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Childhood Immunizations	<i>Multi, Checkboxes.</i> 1: General education (i.e. - member newsletter), 2: Community/employer immunization events, 3: None of the above	<i>Single, Radio group.</i> 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not available	<i>Single, Radio group.</i> 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not available
Immunizations for Adolescents	AS ABOVE	AS ABOVE	AS ABOVE

8.3.6 Health Promotion Programs and Worksite Wellness

8.3.6.1 For your commercial book of business, identify the programs or materials that are offered in this market to support health and wellness for all commercial members, excluding the Plan's own employees in calendar year 2014. **If programs are also available onsite, but are not offered as a standard benefit for all members, please indicate the minimum number of health plan members required to receive the service at no additional charge.**

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.

	Cost of program offering	Minimum number of health plan members required at employer site to offer this service at no additional charge if this is not a standard benefit
Template newsletter articles/printed materials for employer use that include content about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with \$0 cost share under the ACA	<i>Multi, Checkboxes.</i> 1: Standard benefit for all fully insured lives (included in fully insured premium), 2: Standard benefit for all self-insured ASO lives (no additional fee), 3: Employer Option to buy for fully insured lives, 4: Employer Option to buy for self-insured lives, 5: Service/program not available	<i>Decimal.</i> N/A OK. From 0 to 1000000000000.
Customized printed materials for employer use that include content about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with \$0 cost share under the ACA and other Employer plan designs	AS ABOVE	AS ABOVE

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On-site bio-metric screenings (blood pressure, lab tests, bone density, body fat analysis, etc)	AS ABOVE	AS ABOVE
Nutrition classes/program	AS ABOVE	AS ABOVE
Fitness classes/program	AS ABOVE	AS ABOVE
Weight loss classes/program	AS ABOVE	AS ABOVE
Weight management program	AS ABOVE	AS ABOVE
Smoking cessation support program	AS ABOVE	AS ABOVE
24/7 telephonic nurse line	AS ABOVE	AS ABOVE
Inbound telephonic health coaching	AS ABOVE	AS ABOVE
Outbound telephone health coaching (personal outreach and coaching involving live interaction with a person)	AS ABOVE	AS ABOVE
Member care/service reminders (IVR)	AS ABOVE	AS ABOVE
Member care/service reminders (Paper)	AS ABOVE	AS ABOVE
Targeted personal Health Assessment (HA) formerly known as health risk assessment (HRA)	AS ABOVE	AS ABOVE
In-person lectures or classes	AS ABOVE	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	AS ABOVE
Access to PCMH and/or ACO Providers	AS ABOVE	AS ABOVE

8.3.7 Prevention and Treatment of Tobacco Use

8.3.7.1 Indicate the number and percent of tobacco dependent commercial members identified and participating in cessation activities during 2014. **Please provide state or regional counts if available.** If regional/statewide counts are not available, provide national counts.

	Answer
Indicate ability to track identification. Regional/ <u>statewide</u> tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	Multi, Checkboxes. 1: Identification tracked nationally & regionally, including this state/region, 2: Identification tracked nationally and for some regions but not this state/region, 3: Identification only tracked-nationally, 4: Identification not tracked statewide/regionally or nationally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Regional/ <u>statewide</u> tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	Multi, Checkboxes. 1: Participation tracked nationally & regionally, including this state/region, 2: Participation tracked nationally and for some regions but not this state/region, 3: Participation only tracked nationally, 4: Participation not tracked statewide/regionally or nationally, 5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on responses above)	For comparison. 4: Awaiting response to rows above
Total commercial 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 Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	For comparison. TBD

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Number of commercial members individually identified as tobacco dependent in 2014 as of December 2014. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> From 0 to 1000000000.
% of members identified as tobacco dependent	<i>For comparison.</i> 0.00%
Number of members participating in smoking cessation program during 2014 as of December 2014. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> From 0 to 1000000000.
% of identified tobacco dependent members participating in smoking cessation program (# program participants divided by # identified smokers)	<i>For comparison.</i> 0.00%

8.3.7.2 Review the HMO QC 2014 CAHPS data regarding the Plan's regional percentage of current smokers.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the Quality Compass Codes in the attached documents for an explanation of terms.

This answer is supplied by Health Benefit Exchange (individually).

HMO QC CAHPS DATA	2014 CAHPS	2013 CAHPS
Percentage that are current smokers	<i>Percent.</i>	<i>Percent.</i>
Percent of current tobacco users (estimated by CAHPS) that are identified by the plan as tobacco dependent	<i>For comparison.</i> N/A%	

8.3.7.3 Review uploaded PPO QC 2014 CAHPS data regarding the Plan's regional percentage of current smokers. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the Quality Compass Codes in the attached documents for an explanation of terms.

This answer is supplied by Health Benefit Exchange (individually).

PPO QC CAHPS DATA	2014 CAHPS	2013 CAHPS
Percentage that are current smokers	<i>Percent.</i>	<i>Percent.</i>
Percent of current tobacco users (estimated by CAHPS) that are identified by the plan as tobacco dependent	<i>For comparison.</i> N/A%	

8.3.7.4 If Plan supports a Smoking Cessation Support Program, identify how pharmaceutical coverage was covered within the program in calendar year 2014. Refer to response in 3.6.1.

HMO Response	Coverage Options	Copay, deductible, or incentive plan options	Estimated % of lives covered

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Over-the-counter aids (NRT patch, gum, etc) discounted, free, or available at copay	<i>Multi, Checkboxes.</i> 1: Included as part of tobacco cessation program with no additional fee, 2: Available in tobacco cessation program with an additional fee, 3: Available in tobacco cessation program, but may require an additional fee, depending on contract, 4: No tobacco cessation program, but tobacco cessation pharmaceuticals covered under pharmacy benefit for fully insured lives, 5: No tobacco cessation program, but tobacco cessation pharmaceuticals covered under pharmacy benefit for self-insured lives, 6: Not covered	<i>Multi, Checkboxes.</i> 1: Standard copay/discount only, 2: Copay/discount or deductible incentive is variable based on program participation, 3: Medication is available on lowest cost (or no cost) tier, 4: Limitation on number of fills per year, 5: Prior authorization or step therapy required, 6: Available as rider only	<i>Percent.</i> N/A OK.
Bupropion	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.
Varenicline	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.
Prescription Nicotine Patch	AS ABOVE	AS ABOVE	<i>Percent.</i> N/A OK.

8.3.7.5 PPO version of above.

8.3.7.6 Please refer to plan response in 3.6.1 and 3.7.1. Response about participants should be consistent with plan response about geography in 3.7.1. The information in second to last row defines the denominator for this question.

Identify behavioral change interventions used in the tobacco cessation program in calendar year 2014. **These questions are referencing stand-alone tobacco cessation programs.** Enter "Zero" if the intervention is not provided to members in the tobacco cessation program. Check all that apply.

If "Percent receiving intervention" is shown as greater than 100%, please review your response in 3.7.1.

	Availability of intervention	Cost of intervention	Number of participants in 2014 (regional preferred - refer back to 3.7.1)	Is Number of participants provided regional or national number?	Percent receiving intervention (denominator is from 3.7.1 second to last row)
Quit kit or tool kit mailed to member's home	<i>Single, Pull-down list.</i> 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in tobacco cessation program	<i>Multi, Checkboxes.</i> 1: Included as part of tobacco cessation program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No tobacco cessation program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No tobacco cessation program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee), 6: No tobacco cessation program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No tobacco cessation program but intervention available outside of a specific program as a buy-up option for fully insured lives, 8: Not available	<i>Decimal.</i> From 0 to 10000000000000.	<i>Single, Radio group.</i> 1: Regional, 2: National	Unknown
Interactive electronic support	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online professionally facilitated group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online chat sessions non-facilitated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Telephonic counseling program	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In person classes or group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Individual in-person counseling (this does NOT include standard behavioral health therapy where	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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addictions may be addressed)					
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8.3.7.7 If the plan provides in-person or telephonic 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

8.3.7.8 Review the most recent HMO uploaded program results for the tobacco cessation program from QC 2014 and QC 2013.

For the non-NCQA/QC measures "Program defined 6-month quit rate and 12 month quit rate" - please provide the most recent 2 years of information. Indicate all that apply.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

	2014 HMO and QC 2014 results	2013 HMO and QC 2013 results	Describe measure methodology/definition (non HEDIS measures)	Not tracked
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	Health Benefit Exchange (individually). Percent. From -10 to 100.	Health Benefit Exchange (individually). Percent. From -10 to 100.		
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	AS ABOVE	AS ABOVE		
HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	AS ABOVE	AS ABOVE		
Program defined 6-month quit rate	Percent. From 0 to 100.	Percent.	Unlimited.	Multi, Checkboxes - optional. 1: Not tracked
Program defined 12-month quit rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other (describe in "describe measure...")	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.3.7.9 PPO version of above.

8.3.8 Obesity

8.3.8.1 Indicate the number of obese members identified and participating in weight management activities during 2014. Do not report general prevalence. Please provide state or regional counts if available. If regional/statewide counts are not available, provide national counts.

	Answer
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Indicate ability to track identification. Regional/ <u>statewide</u> tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	<i>Multi, Checkboxes.</i> 1: Identification tracked nationally & regionally, including this state/region, 2: Identification tracked nationally and for some regions but not this state/region, 3: Identification only tracked nationally, 4: Identification not tracked statewide/regionally or nationally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Regional/ <u>statewide</u> 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)	<i>For comparison.</i> 4: Awaiting response to rows above
Total commercial 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 Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>For comparison.</i> TBD
Number of commercial plan members identified as obese in 2014 as of December 2014. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> From 0 to 1000000000.
% of members identified as obese	<i>For comparison.</i> 0.00%
Number of commercial plan members participating in weight management program during 2014 as of December 2014. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> From 0 to 1000000000.
% of members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	<i>For comparison.</i> 0.00%

8.3.8.2 Please refer to your response in question above as this response should be consistent with geography noted in your response in 8.3.8.1. Please also refer to response in 8.3.6.1. For plan's total commercial book of business, **identify the interventions offered in calendar year 2014 as part of your weight management program (and are not limited to members seeking bariatric surgery).** Do not consider obesity-centric counseling/behavior change interventions that are associated with other disease management programming. These questions are referencing stand-alone weight management services.
Enter "Zero" if the intervention is not provided to members in the weight management program. Check all that apply. Note that selection of the following four (4) response options require documentation as Healthy 3:

1: Online interactive support, 2: Self-management tools (not online), 3: Family counseling, 4: Biometric devices

If "Percent receiving intervention" is shown as greater than 100%, please review your response in the second to last row in 3.8.1.

	Availability of intervention	Cost of intervention	Number of participants in 2014- regional/statewide preferred - refer to question above	Is Number of participants provided regional/statewide or national?	Percent receiving intervention (denominator is from 3.8.1 second to last row)
Printed (not online) self-management support tools such as BMI wheels, pedometer, or daily food and activity logs	<i>Single, Pull-down list.</i> 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in weight management program	<i>Multi, Checkboxes.</i> 1: Included as part of weight management program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No weight management program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No weight management program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee), 6: No weight management program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No weight management program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	<i>Decimal.</i> From 0 to 1000000000000.	<i>Single, Radio group.</i> 1: Regional, 2: National	Unknown
Web and printed educational materials about BMI and	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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Importance of maintaining a healthy weight					
Online interactive support that might include tools and/or chat sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Telephonic coaching that is obesity-centric. (Obesity is key driver of contact as opposed to discussion in context of some other condition)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In-person group sessions or classes that are obesity centric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Obesity-centric Telephonic or In-person family counseling to support behavior modification	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pedometer and/or biometric scale or other device for home monitoring and that electronically feeds a PHR or EMR	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pharmacological Therapies					
Benefit coverage of FDA approved weight loss drugs	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other					
Affinity programs (e.g. - discounts for Weight Watchers, fitness center discounts)	AS ABOVE	AS ABOVE	Decimal. From 0 to 1000000000000.	Single, Radio group. 1: Regional, 2: National, 3: Offered but not tracked	Unknown

8.3.8.3 If the Plan selected any of the following four (4) weight management activities in the question above, please provide evidence as Healthy 3. Only provide the minimum number of pages as indicated at question above to demonstrate activity. The following evidence is provided:

Multi, Checkboxes.

- 1: Online interactive support (3a).
- 2: Self-management tools (not online) (3b).
- 3: Family counseling (3c).
- 4: Biometric devices (3d).
- 5: Healthy 3 is not provided

8.3.8.4 If the Plan indicated telephonic (obesity centric), in-person individual or group counseling in question 3.8.2 above, please check all that apply about the program.

Multi, Checkboxes.

- 1: Program includes at least 2 sessions per month,
- 2: There is coverage for at least six sessions per year,
- 3: Additional sessions are covered if medically necessary,
- 4: Counseling sessions do not require a copay,
- 5: Counseling is not offered

8.3.8.5 If Plan supports a Weight Management Program and indicated coverage for FDA approved weight loss drugs in question 3.8.2 above, check all that apply. Refer also to response in 3.6.1.

HMO Response	Coverage options	Copay, deductible, or incentive plan options
Over-the-counter aids (e.g. Alli) discounted, free, or available at copay	<p>Multi, Checkboxes.</p> <ul style="list-style-type: none"> 1: Included as part of weight management program with no additional fee, 2: Available in weight management program with an additional fee, 3: Available in weight management program, but may require an additional fee, depending on contract, 4: No weight management program, but weight management pharmaceuticals covered under pharmacy benefit for fully insured lives, 5: No weight management program, but weight management pharmaceuticals covered under pharmacy 	<p>Multi, Checkboxes.</p> <ul style="list-style-type: none"> 1: Standard copay/discount only, 2: Copay/discount or deductible incentive is variable based on program participation, 3: Medication is available on lowest cost (or no cost) tier, 4: Limitation on number of fills per year,

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	benefit for self-insured lives, 6: Not Covered	5: Prior authorization or step therapy required, 6: Available as rider only
Xenical (Orlistat)	AS ABOVE	AS ABOVE
Phentermine or branded equivalents	AS ABOVE	AS ABOVE
Lorcaserin	AS ABOVE	AS ABOVE

8.3.8.6 PPO version of above.

8.3.8.7 For the HMO product, if the plan provides coverage for FDA approved weight loss drugs, describe the eligibility criteria for coverage. For more information on these standards, please see the Purchaser's Guide to Clinical Preventive Services. <http://www.businessgrouphealth.org/benefitstocps/topics/purchasers/fullguide.pdf> (Check all that apply)

Multi, Checkboxes.

- 1: Eligibility criteria indicates coverage for members > 18 years,
- 2: Eligibility criteria indicates BMI > 30 if no other co-morbidities exist,
- 3: Eligibility criteria indicates BMI > 27 with at least one other major risk factor for cardiovascular disease,
- 4: Plan provides coverage, but uses other criteria for coverage (Describe),
- 5: Plan provides coverage, but no criteria for coverage,
- 6: No coverage for FDA approved weight loss drugs

8.3.8.8 PPO version of above.

8.3.8.9 Does the Plan track any of the following outcomes measures related to obesity? Check all that apply.

Multi, Checkboxes.

- 1: Percent change in member BMI,
- 2: Percent of members losing some % of body weight,
- 3: Percent of obese members enrolled in weight management counseling program (program participation rates),
- 4: Percent of members maintaining weight loss over one year interval,
- 5: Reduction in comorbidities in overweight population,
- 6: Other (describe in detail box below),
- 7: No outcomes tracked

8.3.8.10 Review the 2014 and 2013 QC HEDIS uploaded results for the HMO Plan. The HEDIS measures eligible for rotation for QC 2014 are Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents and Adult BMI Assessment.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	2014 HMO QC results	2013 HMO QC results or Prior Year results for Rotated measure
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total) (Eligible for rotation in QC 2014)	Percent. From -10 to 100.	Percent. From -10 to 100.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total) (Eligible for rotation in QC 2014)	AS ABOVE	AS ABOVE.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total) (Eligible for rotation in QC 2014)	AS ABOVE	AS ABOVE.
Adult BMI assessment (Total) (Eligible for rotation in QC 2014)	AS ABOVE	AS ABOVE.

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8.3.8.11 PPO version of above.

8.3.9 CAHPS Performance

8.3.9.1 Review the Plan's HMO CAHPS ratings for the following member communication measures. (CAHPS 29 and CAHPS 8). If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

Provide percentage of members who responded "Always" or "Usually"	HMO QC 2014	HMO QC 2013
Survey Item: How often did the written materials or the Internet provide the information you needed about how your health plan works?	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

8.3.9.2 PPO version of above.

8.3.10 Other Information

8.3.10.1 If the Plan would like to provide additional information about the activities that help members stay/get healthy that was not reflected in this section, provide as Healthy 4.

Is Healthy 4 provided?

Single, Pull-down list.

- 1: Yes with a 4 page limit,
- 2: Healthy 4 is not provided

8.4 HELPING MEMBERS BECOME GOOD CONSUMERS

8.4.1 Instructions and Definitions

8.4.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

8.4.1.2 All attachments to this module must be labeled as "Consumer #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Consumer1a, Consumer 1b, etc.

8.4.1.3 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5.

8.4.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

8.4.2 Addressing language and health literacy needs

8.4.2.1 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

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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 plan activities to address health literacy.

Single, Radio group.

- 1: No activities currently,
- 2: Plan addresses health literacy of members – Describe how health literacy is addressed, including testing of materials: [200 words]

8.4.2.2 Indicate how racial, ethnic, and/or language data is used? 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, or language,
- 3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
- 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

8.4.2.3 How does the Plan support the needs of members with limited English proficiency? Check all that apply.

Multi, Checkboxes.

- 1: Test or verify proficiency of bilingual non-clinical Plan staff,
- 2: Test or verify proficiency of bilingual clinicians,
- 3: Certify professional interpreters,
- 4: Test or verify proficiency of interpreters to understand and communicate medical terminology,
- 5: Train practitioners to work with interpreters,
- 6: Distribute translated lists of bilingual clinicians to members,
- 7: Distribute a list of interpreter services and distribute to provider network,
- 8: Pay for in-person interpreter services used by provider network,
- 9: Pay for telephone interpreter services used by provider network,
- 10: Pay for in-person interpreter services for non-clinical member interactions with plans,
- 11: Negotiate discounts on interpreter services for provider network,
- 12: Train ad-hoc interpreters,
- 13: Provide or pay for foreign language training,
- 14: Formulate and publicize policy on using minor children, other family, or friends as interpreters,
- 15: Notify members of their right to free language assistance,
- 16: Notify provider network of members' right to free language assistance,
- 17: Develop written policy on providing language services to members with limited English proficiency,
- 18: Provide patient education materials in different languages. Percent in a language other than English: [Percent] Media: [Multi, Checkboxes],
- 19: Other (describe in detail box below),
- 20: Plan does not implement activities to support needs of members with limited English proficiency

8.4.2.4 Indicate which of the following activities the Plan undertook in 2014 to assure that culturally competent health care is delivered. 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 Plan staff,
- 11: Sponsor cultural competence training for physician offices,
- 12: Other (describe in detail box below),
- 13: No activities in year of this response

8.4.2.5 Has the Plan evaluated or measured the impact of any language assistance activities? If yes, describe the detail box below the evaluation results of the specific disparities that were reduced and provide a description of the intervention if applicable.

Yes/No.

8.4.3 Alignment of Benefit Design and Incentives

8.4.3.1 Please indicate, if any, consumer incentives for use of the following in HMO/POS product:

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Consumer Tools/Engagement	Incentives Used in HMO/POS (multiple responses allowed)	Other Description
Use of Web Consultation or other telehealth options	<i>Multi, Checkboxes.</i> 1: Agreement with employer on waived or decreased premium share for use, 2: Waived or reduced co-payments or coinsurance, 3: Waived or reduced deductibles, 4: Other (describe), 5: No incentives used	50 words.
Use of Practitioners who have adopted EMR, ePrescribing or other HIT systems	AS ABOVE	AS ABOVE.
Completion & Use of a Personal Health Record (see other questions in section 4.4)	AS ABOVE	AS ABOVE.
Use of provider (hospital or physician) selection tools	AS ABOVE	AS ABOVE.
Enrollment in PCMH/ACO	AS ABOVE	AS ABOVE.
Use of better performing hospitals	AS ABOVE	AS ABOVE.
Use of better performing physicians	AS ABOVE	AS ABOVE.
Completion and use of registration on the plan's member portal so member can see claims, cost and quality on physicians, etc.	AS ABOVE	AS ABOVE.

8.4.3.2 PPO version of above.

8.4.4 Electronic Personal Health Record (PHR)

8.4.4.1 Describe the Plans electronic personal health record.

	Answer
PHR availability	<i>Multi, Checkboxes.</i> 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.

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

- 1) Targeted push message to member based on member profile,
- 2) Member can elect to electronically share selected PHR information with their physicians or facilities,
- 3) Drug checker automatically checks for contraindications for drugs being used and notifies member,
- 4) Member can electronically chart and trend vital signs and other relevant physiologic values, and
- 5) Member defines conditions for push-messages or personal reminders from the Plan.

	Answer
Content	<i>Multi, Checkboxes.</i> 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,

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	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

8.4.4.3 Attachments (Consumer 1a - 1e) are needed to support some of the selections in question 4.4.2 above.

If the Plan selected any of the following five PHR capabilities, provide **actual, blinded screen prints** as Consumer 1: 1) Targeted push message to member based on member profile (1a), 2) Member can elect to electronically share selected PHR information with their physicians or facilities (1b), 3) Drug checker automatically checks for contraindications for drugs being used and notifies member (1c), 4) Member can electronically chart and trend vital signs and other relevant physiologic values (1d), and 5) Member defines conditions for push-messages or personal reminders from the Plan (1e).

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: Consumer 1a is provided (Targeted push message to member based on member profile) is provided,
- 2: Consumer 1b is provided (Member can elect to electronically share selected PHR information),
- 3: Consumer 1c is provided (Drug checker automatically checks for contraindications for drugs being used and notifies member),
- 4: Consumer 1d is provided (Member can electronically chart and trend vital signs and other relevant physiologic values),
- 5: Consumer 1e is provided (Member defines conditions for push-messages or personal reminders from the Plan),
- 6: No attachment

8.4.4.4 Is the PHR portable, enabling electronic member data transfer upon Plan disenrollment? Check all that apply.

Multi, Checkboxes.

- 1: No, but information may be printed or exported as a pdf file by member,
- 2: Yes, the plan provides electronic files that can be uploaded to other PHR programs. (Specify other programs in detail box below),
- 3: Yes, the plan provides software that can be used at home,
- 4: Yes, the vendor/Plan allows continued use on an individual basis at no charge,
- 5: Yes, the vendor/Plan makes this available for continued use for a charge,
- 6: PHR is not portable

8.4.5 Help Finding the Right Doctor

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

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

	Response
Physician office hours	Single, Pull-down list. 1: Displayed only, 2: Indexed and searchable,

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	3: Available from customer service or printed format only, 4: Not available
Physician years in practice	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician facility privileges	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician languages spoken	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Diabetes Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Heart/Stroke Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Back Pain Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Physician Practice Connection Recognition [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Patient-Centered Medical Home Recognition [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Physician Recognition Software Certification - a certification program that supports data collection and reporting for the Diabetes Physician Recognition Program [attach documentation]	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
High performance network participation/status	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Uses web visits [attach documentation]	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Uses patient email [attach documentation]	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Uses ePrescribing [attach documentation]	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Uses EMRs [attach documentation]	<i>Single, Pull-down list.</i> 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available

8.4.5.2 If the Plan selected any of the five (5) items in Question 4.5.1.above, provide actual screen prints illustrating ONLY the following: 1) NCQA recognition programs, availability of: 2) Web visits, 3) email, 4) ePrescribing or 5) EMRs (electronic medical records) as Consumer 2. Please clearly mark on the documentation the feature listed in Question 4.5.1 that is being demonstrated. Do NOT include attachments that do not specifically demonstrate one of these 5 descriptions. Only provide one demonstration per description.

Multi, Checkboxes.

- 1: Consumer 2a on NCQA recognition programs is provided,
- 2: Consumer 2b on use of web visits is provided,
- 3: Consumer 2c on use of email is provided,
- 4: Consumer 2d on use of e-prescribing is provided,

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5: Consumer 2e on use of EMR is provided,
6: Not provided

8.4.5.3 For the HMO, indicate if PUBLIC reports comparing physician (primary care and/or specialty) quality performance are available and used for any of the following categories of PQRS Measure Groups and other additional measures. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars).

Please see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>

Numerator: the number of physicians for which performance information is able to be calculated based on threshold of reliability (not just those informed about reporting)

Denominator (preferred): all PCPs in network and relevant specialists in network that would treat the condition

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in 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 plan 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_12-31-2004.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>

Note that plan does not need to provide documentation for every row selected – only one example from each category (one from A, one from B, etc.)

Category of PQRS Measure & Other Measures	Level of detail for comparative public reporting of physicians who meet the threshold of reliability for reporting. (HMO)	Indicate if reporting covers primary care and/or specialty physicians (HMO)	Description of Other (if plan selected response option 6)	(preferred) Physicians (PCP and SCP) in the relevant specialties being reported on as % of total contracted physicians (Denominator = all PCPs and relevant specialists) (HMO)	(alternate) Physicians being reported on as % total contracted physicians in market (Denominator = all PCPs and all specialists in network) (HMO)
Diabetes Mellitus (A)	<i>Multi, Checkboxes.</i> 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	<i>Multi, Checkboxes.</i> 1: Primary care, 2: Specialty	50 words.	Percent. N/A OK. From 0 to 100.	Percent. N/A OK. From 0 to 100.
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) (B)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Coronary Artery Bypass Graft (C)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Perioperative Care (C)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Back pain (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Coronary Artery Disease (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.

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Heart Failure (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Community-Acquired Pneumonia (D)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Asthma (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
NCQA Recognition program certification (consistent with plan response in directory section) (E)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Patient experience survey data (e.g., A-CAHPS) (F)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Mortality or complication rates where applicable (G)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Efficiency (resource use not unit cost) (H)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Pharmacy management (e.g. generic use rate, formulary compliance) (I)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Medication Safety (J)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Health IT adoption/use (K)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Preventable Readmissions (L)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Preventable ED/ER Visits (NYU) (M)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.

8.4.5.4 PPO version of above.

8.4.5.5 Attach as Consumer 3 screen shots/reports, etc. that support each of the reporting elements (member reports and/or public information) indicated in question above (4.5.3 or 4.5.4) Data contained in these reports must (1) be physician- or medical group-specific, (2) reflect each of the reported elements, (3) include benchmark or target result identified, and (4) labeled or highlighted for ease of review.

Note that plan does not need to provide documentation for every row selected – only one example from each category (one from A, one from B, etc.)

Single, Pull-down list.

- 1: Consumer 3 is provided,
- 2: Not provided

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

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

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

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	5: Physician photograph present for at least 50% of physicians, 6: None of the above
Functionality	Multi, Checkboxes. 1: User can weight preferences, e.g. quality vs. cost, to personalize results, 2: User can rank physicians based on office hours access (e.g., evening or weekend hours), 3: User can rank or filter physician list by culture/demographics (languages spoken, gender or race/ethnicity), 4: User can rank or filter physician list based on HIT adoption (e.g., e-prescribing, Web visits, EMR use), 5: User can rank or filter physician list based on quality indicator(s), 6: User can compare at least three different physicians/practices side-by-side, 7: Plan directs user (during interactive physician selection session) to cost comparison tools (q. 4.8.3) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user), 8: User can link to a physician website, 9: None of the above
Interface/Integration Of Cost Calculator	Multi, Checkboxes. 1: There is a link from tool indicated to cost calculator and user populates relevant information, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe), 4: There is no integration of cost calculator with this tool
Description of "Other"	50 words.

8.4.5.7 If the Plan provides a physician selection tool with any of these five (5) interactive features in question 4.5.6 above, provide actual report(s) or screen prints illustrating each interactive feature checked as Consumer 4a-4e for the following: 1) Performance using disease specific individual measures, 2) Performance using disease-specific composite measures, 3) User can rank/filter physician list by culture/demographics, 4) User can rank/filter physician based on HIT adoption, 5) User can rank/filter physician based on quality indicators.

Do not provide a copy of the provider directory or replicate information supplied in Question 4.5.2, and do NOT include attachments that do not specifically demonstrate one of these 5 features. Please clearly mark on the documentation the feature listed in Question 4.5.6 that is being demonstrated. Only provide one demonstration per description.

Multi, Checkboxes.

- 1: Consumer 4a (Performance using disease specific individual measures) is provided,
- 2: Consumer 4b (Performance using disease-specific composite measures,) is provided,
- 3: Consumer 4c (User can rank/filter physician list by culture/demographics) is provided,
- 4: Consumer 4d (User can rank/filter physician based on HIT adoption) is provided,
- 5: Consumer 4e (User can rank/filter physician based on quality indicators) is provided,
- 6: Not provided

8.4.5.8 How does the Plan encourage members to use better performing physicians? Check all that apply.

	Answer
Distinction of higher performing individual physicians	<i>Single, Radio group.</i> 1: No distinction, 2: Distinction is made
General education about individual physician performance standards	<i>Single, Radio group.</i> 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

8.4.5.9 Provide information regarding the Plan's capabilities to support physician-member consultations using technology (e.g., web consultations, telemedicine) Check all that apply for HMO.

Preference is regional/statewide, if regional/statewide response is not available, please provide a national response.

HMO Response	Answer	Technology	Geography of response
Plan ability to support web/telehealth consultations	Multi, Checkboxes. 1: Plan does not offer/allow web or telehealth consultations, 2: Web visit with structured data input of history and symptom, 3: Telehealth with interactive face to face dialogue over the Web		<i>Single, Radio group.</i> 1: Regional, 2: National

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Plan uses a vendor for web/telehealth consultations (indicate vendor)	50 words.	Single, Radio group. 1: Web, 2: Telehealth, 3: Combination of Web and Telehealth	AS ABOVE
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 Plan has and tracks use by Medi-Cal members as well, enrollment 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 Plan has and tracks use by Medi-Cal members as well, enrollment 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 2014 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 Plan has and tracks use by Medi-Cal members as well, enrollment 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 2013 per thousand members	Decimal. N/A OK.	AS ABOVE	AS ABOVE
Plan provides a structured template for web/telehealth consultations (versus free flow email)	Single, Radio group. 1: Yes, 2: No	AS ABOVE	AS ABOVE
Plan reimburses for web/telehealth consultations	Single, Radio group. 1: Yes, 2: No	AS ABOVE	AS ABOVE
Plan's web/telehealth consultation services are available to all of members/employers	Single, Radio group. 1: Yes - with no additional fee, 2: Yes - additional fee may be assessed, depending on contract, 3: Yes - always for an additional fee, 4: No	AS ABOVE	AS ABOVE

8.4.5.10 PPO version of above.

8.4.6 Hospital Choice Support

8.4.6.1 For the plan's commercial book of business, indicate if **PUBLIC REPORTS** comparing **HOSPITAL quality** performance are available for any of the following categories of Measure Groups. Check all that apply and provide documentation of reporting as Consumer 5 in question below. Note that these are the same measures in 2.10.4

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

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

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:

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- [Prevention Quality Indicators](http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx) 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](http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx) 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](http://www.qualityindicators.ahrq.gov/Modules/psi_overview.aspx) 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 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_12-31-2004.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbqh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

	% total contracted HOSPITALS INCLUDED in PUBLIC REPORTING in market	Description of Other
HQA		
ACUTE MYOCARDIAL INFARCTION (AMI)	Percent. N/A OK. From 0 to 100.	
HEART FAILURE (HF)	AS ABOVE	
PNEUMONIA (PNE)	AS ABOVE	
SURGICAL INFECTION PREVENTION (SIP)	AS ABOVE	
Surgical Care Improvement Project (SCIP)	AS ABOVE	
PATIENT EXPERIENCE/H-CAHPS	AS ABOVE	
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/leapfrog_safety_practices		
Leapfrog Safety Score	AS ABOVE	
Adoption of CPOE	AS ABOVE	
Management of Patients in ICU	AS ABOVE	
Evidence-Based Hospital referral indicators	AS ABOVE	
Adoption of NQF endorsed Safe Practices	AS ABOVE	
Maternity – pre 39 week elective induction and/or elective c-section rates	AS ABOVE	
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*		
Inpatient quality indicators http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx	AS ABOVE	

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Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	AS ABOVE	
Prevention quality indicators http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx	AS ABOVE	
OTHER MEASURES		
HACs – healthcare acquired conditions also known as hospital acquired conditions (e.g., Surgical site infection following coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	AS ABOVE	
SREs (serious reportable events) that are not HACs (e.g., surgery on the wrong body part or wrong patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx (see attachment)	AS ABOVE	
Readmissions	AS ABOVE	
ED/ER Visits	AS ABOVE	
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)		
ICU Mortality	AS ABOVE	
HIT adoption/use	AS ABOVE	
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	AS ABOVE	
Other standard measures endorsed by National Quality Forum (describe):	AS ABOVE	200 words.

8.4.6.2 Provide an actual, blinded sample report or screen shot illustrating hospital performance comparative public reporting information indicated in the question above as Consumer 5. Data contained in these reports must be hospital-specific and reflect the feedback elements identified in question above. If the information comes from a vendor or public website and the Plan does not directly communicate the results to the hospitals, the Plan must demonstrate the process followed by the source to share the information (results and methodology) with the hospitals. Note that links to public websites do not qualify.

Single, Pull-down list.

- 1: Consumer 5 is provided,
- 2: Not provided

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

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

	Answer
Availability	<i>Single, Radio group.</i> 1: Hospital chooser tool is available, 2: Hospital chooser tool is not available
Search features	<i>Multi, Checkboxes.</i> 1: Supports search for hospital by name, 2: Supports search for hospitals within geographic proximity, 3: Supports hospital-wide attribute search (e.g., number of beds, major service areas, academic medical center, etc.), 4: Supports condition-specific search, 5: Supports procedure-specific search, 6: Supports search for hospital-affiliated physicians, 7: Supports search for hospital-affiliated physicians that are plan contracted, 8: Supports search for plan-affiliated (in-network) hospitals, 9: Supports search for in-network hospital or includes indication of such, 10: None of the above
Content	<i>Multi, Checkboxes.</i> 1: Provides education about condition/procedure performance vs. overall hospital performance,

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	<p>2: Provides education about the pertinent considerations for a specific procedure or condition, 3: Describes treatment/condition for which measures are being reported, 4: Distinguishes between condition-specific and hospital-wide performance, 5: Discloses reference documentation of evidence base for performance metrics (methodology, population, etc.), 6: Discloses scoring methods, (e.g., case mix adjustment, measurement period), 7: Discloses dates of service from which performance data are derived, 8: Reports adherence to Leapfrog patient safety measures, 9: Reports performance on AHRQ patient safety indicators, 10: Reports volume as proxy for outcomes if relevant to treatment, 11: Reports complication indicators if relevant to treatment, 12: Reports never events, 13: Reports HACs (healthcare acquired conditions also known as hospital-acquired conditions), 14: Reports mortality if relevant to treatment, 15: Performance charts or graphics use the same scale for consistent presentation, 16: Communicate absolute risks or performance values rather than relative risks, 17: Some indication of hospital efficiency rating, 18: None of the above</p>
Functionality	<p><i>Multi, Checkboxes.</i> 1: Consumer can weight preferences (e.g. quality vs. cost) to personalize results, 2: Consumer can choose a subset of hospitals to compare on distinct features, 3: Plan directs user (during interactive hospital selection session) to cost comparison tools (q. 2.7.4) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user), 4: None of the above</p>
Interface/Integration Of Cost Calculator	<p><i>Multi, Checkboxes.</i> 1: There is a link from tool to cost calculator and user populates relevant information, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe), 4: There is no integration of cost calculator with this too</p>
Description of "Other"	<p>200 words.</p>

8.4.6.4 Refer to response in question 4.6.3 above. If any of the following interactive feature were selected: 1) Distinguishes between condition-specific and hospital-wide performance, 2) Discloses scoring methods, 3) Reports never events, 4) Reports mortality if relevant to treatment, 5) User can weight preferences (e.g. quality vs. cost) to personalize results; **provide documentation as Consumer 6** actual report(s) or screen prints illustrating each interactive feature selected

The features demonstrated in the attachment must be clearly marked. Reviewers will only be looking for indicated features that are checked below and that are emphasized in the attachment. Do NOT include attachments that do not specifically demonstrate one of these 5 features. Please clearly mark on the documentation the feature listed in Question 4.6.3 that is being demonstrated. Only provide one demonstration per description.

Multi, Checkboxes.

- 1: Consumer 6a (Distinguishes between condition-specific and hospital-wide performance) is provided,
- 2: Consumer 6b (Discloses scoring methods) is provided,
- 3: Consumer 6c (Reports never events) is provided,
- 4: Consumer 6d (Reports mortality if relevant to treatment) is provided,
- 5: Consumer 6e (User can weight preferences (e.g. quality vs. cost) to personalize results) is provided,
- 6: Not provided

8.4.7 Shared Decision-Making and Treatment Option Support

8.4.7.1 Does the Plan provide members with any of the following treatment choice support products? Check all that apply.

Multi, Checkboxes.

- 1: Treatment option support is not available,
- 2: BestTreatments,
- 3: HealthDialog Shared Decision Making Program,
- 4: Healthwise Decision Points,
- 5: NexCura NexProfiler Tools,
- 6: Optum Treatment Decision Support,
- 7: WebMD Condition Centers,
- 8: Other (name vendor in detail box below):,
- 9: Plan 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

8.4.7.2 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 Consumer 7:

- 1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
- 2) Treatment options include benefits and risks (7b),
- 3) Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision (7c),
- 4) Information tailored to the progression of the member's condition (7d),
- 5) Treatment cost calculator based on the Plan's fee schedule and selection of specific providers (7e), and
- 6) Linked to the member's benefit coverage to reflect potential out-of-pocket costs (7f)

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

	Answer
Content	Multi, Checkboxes. 1: Describes treatment/condition, i.e. symptoms, stages of disease, and expectations/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: Plan or vendor may make outbound call to targeted member based on identified triggers (e.g., course of treatment, authorization request, etc.), 3: None of the above
Member Specificity	Multi, Checkboxes. 1: Tailored to member's demographic attributes (e.g., age, gender, etc.), 2: Tailored to the progression of the member's condition, 3: Elicits member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.), 4: Tailored to member's specific benefits design, such that co-pays, OOP max, deductible, FSA and HSA available funds, and relevant tiered networks or reference pricing are all present in cost information, 5: None of the above
Cost Information/functionality	Multi, Checkboxes. 1: Treatment cost calculator based on the Plan's fee schedule but not tied to selection of specific providers, 2: Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, 3: Treatment cost calculator based on billed charges in the local market, 4: Treatment cost calculator based on paid charges in the local market, 5: Specific to the member's benefit coverage (co-pays, OOP max, deductible, FSA and HSA available funds) to reflect potential out-of-pocket costs, 6: Treatment cost calculator includes medication costs, 7: Treatment cost calculator does not include medication costs – information is not integrated, 8: Treatment cost per an alternative method not listed above (describe in detail box below);, 9: None of the above
Interface/Integration Of Cost Calculator	Multi, Checkboxes. 1: There is a link from tool to cost calculator and user populates relevant information., 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe in detail box below), 4: There is no integration of cost calculator with this tool
Description of "Other"	200 words.

8.4.7.3 If any of the following six (6) features are selected in question 4.7.2 above, actual report(s) or screen prints illustrating each interactive feature selected for the procedure **KNEE REPLACEMENT** as Consumer 7: 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: Consumer 7a (Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)) is provided,
- 2: Consumer 7b (Treatment options include benefits and risks) is provided,
- 3: Consumer 7c (Provides patient narratives/testimonials) is provided,
- 4: Consumer 7d (Information tailored to the progression of the member's condition) is provided,
- 5: Consumer 7e (based on the Plan's fee schedule and selection of specific providers) is provided,
- 6: Consumer 7f (Linked to the member's benefit coverage to reflect potential out-of-pocket costs) is provided,
- 7: Not provided

8.4.7.4 Does the plan use any of the following activities to identify members who would benefit from treatment decision support? Check all that apply.

Multi, Checkboxes.

- 1: Claims or clinical record profiling,
- 2: Specialty care referral process,
- 3: Personal Health Assessment,
- 4: Nurse advice line referral,

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- 5: Care/case management support,
- 6: None of the above activities are used to identify specific treatment option decision support outreach

8.4.7.5 How does the Plan evaluate the use and impact of its treatment option support? The commercial enrollment reported below should match the statewide number reported in Profile 1.3.3. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.

	2014	2013
Use/impact not evaluated or tool not available	<i>Multi, Checkboxes - optional.</i> 1: Not available	<i>Multi, Checkboxes - optional.</i> 1: Not available
Total commercial enrollment from plan's response in profile 1.3.3 (sum of commercial HMO/POS, PPO and Other Commercial)	<i>For comparison.</i> 0	
Enrollment (list Total commercial number reported in Profile 1.3.3). If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i>	<i>Decimal.</i>
Number of completed interactive sessions with treatment option support tool	<i>Decimal.</i> N/A OK. From 0 to 10000000000000.	<i>Decimal.</i> N/A OK. From 0 to 10000000000000.
Number of unique users to site. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> N/A OK. From 0 to 1000000000.	<i>Decimal.</i> N/A OK. From 0 to 1000000000.
Number of unique users making inbound telephone calls. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> N/A OK.	<i>Decimal.</i> N/A OK.
Number of unique users receiving outbound telephone calls. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.	<i>Decimal.</i> N/A OK.	<i>Decimal.</i> N/A OK.
Percentage of unique Website users to total enrollment [autocalc]	<i>For comparison.</i> 0.00%	<i>For comparison.</i> 0.00%
Percentage of unique users for telephonic treatment option decision support (inbound and outbound) [autocalc]	<i>For comparison.</i> 0.00%	<i>For comparison.</i> 0.00%
Targeted follow-up via email or phone call to assess user satisfaction	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Single, Radio group.</i> 1: Yes, 2: No
Measuring change in utilization patterns for preference-sensitive services (e.g., back surgery, prostate surgery, etc.)	<i>Multi, Checkboxes.</i> 1: Volume of procedures, 2: Paid claims, 3: None of the above	<i>Multi, Checkboxes.</i> 1: Volume of procedures, 2: Paid claims, 3: None of the above
Plan can report utilization aggregated at the purchaser level	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Single, Radio group.</i> 1: Yes, 2: No

8.4.8 Price Transparency - Helping Members Pay the Right Price (Understand Cost)

8.4.8.1 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: Plan does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

8.4.8.2 Describe the web-based cost information that the Plan makes available for physician and hospital services. Check all that apply.

	Physicians	Hospitals	Ambulatory surgery or diagnostic centers
Procedure-based cost	<i>Multi, Checkboxes.</i> 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,	<i>Multi, Checkboxes.</i> 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,	<i>Multi, Checkboxes.</i> 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,

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	7: Information available only to members, 8: Information available to public	7: Information available only to members, 8: Information available to public	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

8.4.8.3 Indicate the functionality available in the Plan's cost calculator. Check all that apply. If any of the following five (5) features are selected, documentation for the procedure KNEE REPLACEMENT must be provided in following question as Consumer 8:

- 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,
- 5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

	Answer
	<i>Multi, Checkboxes - optional.</i> 1: The Plan does not support a cost calculator.
Content	<i>Multi, Checkboxes.</i> 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	<i>Multi, Checkboxes.</i> 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	<i>Multi, Checkboxes.</i> 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 plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above
Account management / functionality	<i>Multi, Checkboxes.</i> 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

8.4.8.4 If any of the following five (5) features are selected in question 4.8.3 above, actual report(s) or illustrative screen prints for the procedure KNEE REPLACEMENT must be attached as Consumer 8:

- 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,
- 5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

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: Consumer 8a is provided,
2: Consumer 8b is provided,
3: Consumer 8c is provided,
4: Consumer 8d is provided,
5: Consumer 8e is provided,
6: Not provided

8.4.9 HEDIS and CAHPS Performance

8.4.9.1 Review the Plan's HMO CAHPS ratings for the following composite measures.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	HMO QC 2014	HMO QC 2013
Getting needed care composite Provide percentage of members who responded "Always" or "Usually"	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Getting care quickly composite Provide percentage of members who responded "Always" or "Usually"	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Customer service composite Provide percentage of members who responded "Always" or "Usually"	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

8.4.9.2 PPO version of above.

8.4.10 Other Information

8.4.10.1 If the Plan would like to provide additional information about its approach to helping members become better consumers that was not reflected in this section, provide as Consumer 9.
Is Consumer 9 provided

Single, Pull-down list.
1: Yes with a 4 page limit,
2: No

8.5 HELPING MEMBERS MANAGE ACUTE/ EPISODIC CONDITIONS AND ADVANCED CARE

8.5.1 Alignment of Plan Design

8.5.1.1 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for acute care services by any of the means listed in the "Financial incentives" column? In the "Uptake" column, estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes). In the "Product Availability" column, indicate the plan product types in which the incentive feature is available. "Acute episodes of care" refers to instances where members might share in the choice of treatment setting or modality (e.g. in-patient vs. outpatient, open vs. laparoscopic surgery).

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

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

Please respond accordingly in the last column.

HMO Response- Acute Care Services	Financial Incentives	Product availability	Uptake as % of total commercial statewide membership as noted in 1.3.3	Percentage is based on plan's entire commercial membership in all markets of plan operation
A: Incentives contingent upon member behavior				

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Participation in shared decision program prior to proceeding with treatment	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	Multi, Checkboxes. 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	Percent. N/A OK. From 0 to 100.	Yes/No.
B: Incentives not contingent on participation or completion				
Use of more cost-effective treatment alternatives	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	Multi, Checkboxes. 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	Percent. N/A OK. From 0 to 100.	Yes/No.

8.5.1.2 PPO version of above

8.5.2 Obstetrics and Maternity and Child

8.5.2.1 Which of the following activities does the plan undertake to promote pre-conception counseling? Pre-conception counseling is defined as counseling or a consult with women of child-bearing age regardless of whether the women are actively attempting or planning a pregnancy. For more information about preconception counseling, see <http://www.cdc.gov/ncbddd/preconception/>. A "Reproductive Life Plan" is a written account of a woman's general plan for pregnancy and childbirth and may include elements of timing, budgeting, birth control, delivery preferences, principles of child-rearing, etc. Check all that apply.

	Answer
Plan promotes preconception counseling	<i>Single, Radio group.</i> 1: Yes, 2: No
General education to practitioners about importance of preconception counseling for all women of child-bearing age	AS ABOVE
Targeted education to practitioners treating women with pre-existing health conditions, (e.g. diabetes, HIV, high blood pressure, etc.) about the importance of pre-conception counseling	AS ABOVE
General education to women of child bearing age about the importance of pre-conception counseling in newsletters, etc.	AS ABOVE
Targeted education to women with pre-existing health conditions, (e.g diabetes, HIV, high blood pressure, etc.) about the importance of preconception counseling	AS ABOVE
Templates or other tools to assist practitioners with the development of a Reproductive Life Plan (describe):	200 words. N/A OK.
Interactive web tool for self-development of Reproductive Life Plan	<i>Single, Radio group.</i> 1: Yes, 2: No
Endorses or promotes screening for known risk factors according to guidelines set forth by the American College of Obstetrics and Gynecology for all women who are planning a pregnancy (describe):	200 words. N/A OK.
Other (describe):	<i>Unlimited.</i> Nothing required

8.5.2.2 How does the plan monitor that practitioners are screening pregnant women for tobacco and alcohol use?

	Type of Monitoring	Detail
Screening pregnant women for alcohol use at the beginning of each pregnancy	Multi, Checkboxes. 1: Screening is not monitored, 2: Chart audit, 3: Survey/Self report, 4: Other monitoring method (Describe in detail box), 5: This screening is recommended, but not monitored, 6: This screening is not recommended	200 words.

Covered California

Screening pregnant women for tobacco use and counseling to quit at every provider visit	AS ABOVE	AS ABOVE
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8.5.2.3 Indicate all of the following that describe the Plan's policies regarding normal (not high risk) labor and delivery. Check all that apply.

Multi, Checkboxes.

- 1: Includes one pre-conception pregnancy planning session as part of the prenatal set of services,
- 2: Mid-wives credentialed and available for use as primary provider,
- 3: Coverage for Doula involvement in the delivery,
- 4: Coverage for home health nurse visit post-discharge,
- 5: Systematic screening for post-partum depression (describe in detail box below),
- 6: None of the above

8.5.2.4 Please report the 2014 and 2013 Cesarean delivery rates and VBAC rates using the AHRQ, NQF and Joint Commission specifications. Please see the attachment for the Admission to NICU (Neonatal Intensive Care) worksheet to respond to question on NICU admissions. The document can also be found in "Manage Documents".

Regional/Statewide responses are preferred.

Detailed specifications can be accessed here:

AHRQ: Cesarean Delivery Rate: http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V41/TechSpecs/IQI_33_Primary_Cesarean_Delivery_Rate.pdf

NQF: NTSV Cesarean Rate: <http://manual.jointcommission.org/releases/TJC2014A/MIF0167.html>

Joint Commission: Rate of Elective Deliveries: <http://manual.jointcommission.org/releases/TJC2014A/MIF0166.html>

AHRQ: VBAC Rate Uncomplicated: <http://www.qualitymeasures.ahrq.gov/content.aspx?id=38511>

NQF: NICU Admission Rates: See attached PDF

	Calculated	2014 Statewide Rate	2013 Statewide Rate	2014 Rate in market	2013 Rate in market
AHRQ Cesarean Delivery Rate	<i>Single, Radio group.</i> 1: Calculated, 2: Not calculated	<i>Percent.</i> N/A OK. From -10 to 100.	<i>Percent.</i> N/A OK. From -10 to 100.	<i>Percent.</i> N/A OK. From -10 to 100.	<i>Percent.</i> N/A OK. From -10 to 100.
NQF NTSV Cesarean Delivery Rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Joint Commission Rate of Elective Deliveries	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
AHRQ VBAC Rate Uncomplicated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
NQF NICU Admission Rates	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.5.2.5 Review the two most recently uploaded QC 2014 and QC 2013 HMO results for the Plan for each measure listed.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	HMO QC 2014, or Most Current Year HMO QC Results	2013 HMO QC results or Prior Year QC Results
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Covered California

Chlamydia Screening in Women - Total	Percent. From -10 to 100.	Percent. From -10 to 100.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	AS ABOVE	AS ABOVE
Prenatal and Postpartum Care - Postpartum Care	AS ABOVE	AS ABOVE
Well-Child Visits in the first 15 months of life (6 or more visits)	AS ABOVE	AS ABOVE
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	AS ABOVE	AS ABOVE
Adolescent Well-Care Visits	AS ABOVE	AS ABOVE

8.5.2.6 PPO version of above.

8.5.2.7 Identify Plan strategies in calendar year 2014 for payment, education and policy initiatives designed to address the rising rates of cesarean deliveries and elective inductions. Check all that apply. **Indicate whether related to cesarean delivery and/or inductions, and include relevant results of efforts.**

Please ensure your response in 2.10.5 is consistent with your response to this question.

	Activities	Description (are responses related to cesarean delivery or inductions, other payment model, results)
Payment	Multi, Checkboxes. 1: Bundled payment for professional fee for labor and delivery (or other scope of maternity care), 2: Bundled payment for facility fee for labor and delivery (or other scope of maternity care), 3: Bundled payment for professional and facility fee for labor and delivery (or other scope of maternity care), 4: Blended single payment for cesarean delivery and vaginal births for professionals, 5: Blended single payment for cesarean delivery and vaginal births for facilities, 6: Financial incentives or penalties for professionals to reduce elective cesarean deliveries and/or inductions, 7: Financial incentives or penalties for facilities to reduce elective cesarean deliveries and/or inductions, 8: Other (describe), 9: None of the above	100 words. N/A OK.
Education	Multi, Checkboxes. 1: Supply of member education materials for provider use and dissemination, 2: Direct member education (describe), 3: Practitioner education (describe), 4: Facility education (describe), 5: None of the above	65 words. N/A OK.
Policy	Multi, Checkboxes. 1: Contracts establishing required changes in facility policy regarding elective births prior to 39 weeks, 2: Contracts establishing required changes in professional policy regarding elective births prior to 39 weeks, 3: Credential certified nurse midwives and certified midwives, 4: None of the above	

8.6 HELPING MEMBERS MANAGE CHRONIC CONDITIONS

8.6.1 Instructions and Definitions

8.6.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

8.6.1.2 All attachments to this module must be labeled as "CC #" and submitted electronically. If more than one attachment is needed for a particular response, they should be labeled CC 1a, 1b, 1c, etc. Please keep the number of attachments to the minimum needed to demonstrate your related RFI responses.

8.6.1.3 The Plan is asked to describe its chronic condition management program organization, including the use of outside vendors. Chronic condition management programs consist of formal programs that (1) identify members with chronic disease including behavioral health conditions such as depression, (2) conduct member and practitioner outreach for compliance and health improvement, and (3) address care coordination. Educational messages only are insufficient for consideration of a formal program. **Plans that use vendors for disease management should coordinate their answers with their vendor.**

Covered California

8.6.1.4 This module focuses on Coronary Artery Disease, Diabetes and Behavioral Health. Asthma was eliminated as an area of focus for 2010 due to its reliance on limited HEDIS indicators and process questions, but is being reinstated for Covered California as it is a condition of interest. Back pain was eliminated in 2012 because the condition did not coordinate well with diabetes and CAD. Questions are asked in "Program Scope" about other clinical programs to understand breadth of the Plan's disease management efforts. Employers may request information on these programs outside of the eValue8 initiative.

8.6.1.5 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

8.6.1.6 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

8.6.2 Program Availability (Standard or Buy-Up) and Co-ordination

8.6.2.1 For the commercial book of business, indicate the reach of chronic condition management programs offered. **If a condition is only managed as a comorbidity within another program, the Plan should indicate the condition is managed only as a comorbidity and identify (as text in the last column) the primary condition(s) linked to the comorbidity.** The distinction "available to all" versus "an option to purchase" should be provided only for these primary managed conditions where the Plan proactively identifies all members with the condition for program interventions - not just among those who have been identified with another condition (not comorbidity managed conditions). If the program is administered fully or jointly indicate the vendor name.

If response for column "Reach of chronic condition management programs offered" differs based on product offered (HMO versus PPO) and plan is responding for BOTH products - please select the option that covers most of the membership (most common) and note the other in the additional information section.

Total Population Management (TPM): An approach that provides services and programs for members across different conditions and risk factors. A total population management approach provides a full range of services to chronic, at-risk and acute conditions with a focus on health/wellness, prevention, and self-care. Risk based TPM is the Targeting of specific services is based on a client's risk factors and not only diagnosed conditions. A hallmark of this approach is its reliance on care coordination, and requires a unified case file and unified case management.

	Reach of condition management programs offered	Cost of Program Availability	Vendor Name if plan outsources or jointly administers	*Specify primary condition(s) (If applicable)
Alzheimer's disease	<i>Multi, Checkboxes.</i> 1: Plan-wide and available to all commercial members identified with condition., 2: Managed only as a comorbidity (*specify primary condition(s)) 3: Available in all markets including this one, 4: Available only in specific markets including this one, 5: Available only in specific markets BUT NOT this one, 6: No disease management program	<i>Multi, Checkboxes.</i> 1: Available to fully insured members as part of standard premium, 2: Available as part of standard ASO fee for self-insured members (no additional fee assessed), 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members	50 words. Nothing required	65 words.
Arthritis (osteo and/or rheumatoid)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma - Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Back pain	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
CAD (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.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Cancer	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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Chronic obstructive pulmonary disease (COPD)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Congestive heart failure (CHF)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
High risk pregnancy	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Migraine management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pain management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Stroke	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Risk factor based total population management (Not disease specific)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.6.2.2 Describe how (1) care coordination is handled for an individual member across comorbid conditions (e.g. a member diagnosed with coronary artery disease and diabetes or depression). If one or more chronic condition management programs are outsourced to a vendor, identify how the vendor manages care coordination for an individual member across comorbid conditions; and (2) how pharmacy management is integrated in chronic condition management programs. Chronic condition management programs consist of formal programs that (1) identify members with the chronic condition, (2) conduct member and practitioner outreach for compliance and health improvement, and (3) address care coordination. **Educational messages only are insufficient for consideration of a formal program.**

	Response
Describe how care is coordinated for member with co-morbid conditions including depression	200 words.
Describe how pharmacy management is integrated in CCM (chronic condition management) programs	200 words.

8.6.2.3 For patient-centered care, it is important that outreach to patients is seamless and coordinated. **Select the one** response that best describes the Plan's Chronic Condition Management (CCM) system administration arrangement.

The first response of "Data is electronically populated in a unified record for DM care management" can **ONLY BE SELECTED IF**:

- 1) the information is electronically entered into the record from another electronic source like claims or a web-based electronic personal health assessment tool without manual re-entry or entry resulting from contact with the plan member, AND
- 2) there is a single case record per member that unifies all care management functions conducted by the plan, including large case management, disease management, health and wellness coaching, etc.

Response option 1 can also be selected IF the nurse/case manager enters their notes directly into an electronic DM case record.

	System administration arrangement for disease management
Inpatient medical claims/encounter data	<p><i>Single, Radio group.</i></p> <p>1: Data is electronically populated in a unified record for DM care management for all members, 2: Data is manually entered into a unified record for all members, 3: Data is electronically populated in a unified record for DM care management for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH), 4: Data is manually entered into a unified record for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH), 5: This functionality / element is not available or is manually entered by care management staff</p>
Medical claims/encounter data	AS ABOVE
Pharmacy claims data	AS ABOVE

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Lab test claims data	AS ABOVE
Lab values	AS ABOVE
Behavioral health claims/encounter data	AS ABOVE
Member response to a Health Assessment (HA), formerly known as PHA or HRA) if available	AS ABOVE
Results from home monitoring devices (electronic scales, Health Buddy, heart failure monitoring devices, etc)	AS ABOVE
Results from worksite biometric or worksite clinic sources	AS ABOVE
Information from case manager or nurses notes	AS ABOVE

8.6.2.4 For patient-centered care, it is important that outreach to patients is seamless and coordinated. Select the one response that best describes the Plan's Medical Management Service and timing for initial outreach. Check all that apply.

	Medical Management Services	Describe
When do you initiate outreach for case management referrals?	<i>Single, Radio group.</i> 1: Within 24-48 hours, 2: Within 3-5 business days, 3: Within 6-10 business days, 4: Other (describe)	50 words.
Do you have a program that provides help to an individual transitioning between care settings?	<i>Multi, Checkboxes.</i> 1: Home to and from Hospital, 2: Skilled Nursing Care to and from Hospital, 3: Rehabilitation Care to and from Hospital, 4: Other (describe)	500 words.
Describe how you identify and engage high-risk, medically complex patients for a high-intensity case management program.	<i>Single, Radio group.</i> 1: Provider referral, 2: Prospective risk score (include threshold and methodology description), 3: Frequency of admission or emergency department use, 4: Outbound call to patient, 5: Face-to-face patient visit, 6: Other (describe)	500 words.
Describe the measurement strategy in your high-intensity case management programs.	<i>Multi, Checkboxes.</i> 1: Member Satisfaction, 2: Inpatient Admission Rates, 3: Emergency Department Use Rates, 4: Complication Rates, 5: Readmission Rates, 6: Clinical Outcome Quality, 7: Other (describe), 8: No Measurement Strategy in Place	500 words.

8.6.2.5 How does the Plan determine and ensure that members with chronic conditions are screened for depression 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.** Availability of the general Plan HA (Health Assessment) does NOT qualify unless it is specifically promoted to members in the Chronic Condition Management (CCM) program (not just through general messages to all health plan members) and used by the CCM program staff.

	Response	Means of Determination	If "Other Means of Determination" selected as response - describe
Coronary Artery Disease	<i>Single, Radio group.</i> 1: Depression is not assessed, 2: Survey/nurse assessment of select DM program members (only high risk individuals receive screening), 3: Survey/nurse assessment of select DM program members (medium and high risk individuals receive screening), 4: Survey/nurse assessment of all DM program members (all risk levels receive screening)	<i>Multi, Checkboxes.</i> 1: Survey, 2: Nurse, 3: IVR, 4: Other (Specify)	100 words.
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE

Covered California

8.6.2.6 How does the Plan determine and ensure members are screened and, if appropriate, treated for overweight/obesity (BMI) based on the level of risk segmentation? Availability of the general Plan HA (Health Assessment) does NOT qualify unless it is specifically promoted to members in the Chronic Condition Management (CCM) program (not just through general messages to all health plan members) and used by the CCM program staff. Check all that apply.

	Response	Means of Determination	If "Other Means of Determination" selected as response - describe
Coronary Artery Disease	<i>Single, Radio group.</i> 1: BMI is not assessed. 2: Survey/nurse assessment of select DM program members (only high risk individuals receive screening). 3: Survey/nurse assessment of select DM program members (medium and high risk individuals receive screening). 4: Survey/nurse assessment of all DM program members (all risk levels receive screening)	<i>Multi, Checkboxes.</i> 1: Survey, 2: Nurse, 3: IVR, 4: Other (specify)	<i>100 words.</i>
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE

8.6.3 Member Identification and Support for CAD, Diabetes and Asthma

8.6.3.1 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for **services related to chronic conditions** by any of the means listed in the "Financial incentives" column? In the "Uptake" column, **estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes).** In the "Product Availability" column, indicate the plan product types in which the incentive feature is available.

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

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

Please respond accordingly in the last column.

HMO Response - services related to chronic conditions	Financial Incentives	Product availability	Uptake as % of total commercial statewide membership noted in 1.3.3	Percentage is based on plan's entire commercial membership in all markets of plan operation
A: Incentives contingent upon member behavior				
Participation in Plan-approved Patient-Centered Medical Home Practices	<i>Multi, Checkboxes.</i> 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 biometric goals (e.g., BMI level or change, HbA1c improvement or levels, etc.). 5: Waived or decreased co-payments/deductibles for use of selected chronic care medications. 6: Incentives to adhere to evidence-based self-management guidelines. 7: Incentives to adhere to recommended care coordination encounters. 8: Not supported	<i>Multi, Checkboxes.</i> 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Yes/No.</i>
Participation in other Plan-designated high performance practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Participation in chronic condition management coaching	<i>Multi, Checkboxes.</i> 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	AS ABOVE	AS ABOVE	AS ABOVE

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Adherence to chronic condition management guidelines (taking tests, drugs, etc. as recommended)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success with specific target goals for chronic condition management (HbA1c levels, LDL levels, BP levels, etc.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
B. Incentives not contingent on participation or completion				
Asthma	Multi-Checkboxes: 1: Whether just 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	AS ABOVE	AS ABOVE	Yes/No.
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Depression	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.6.3.2 PPO version of above.

8.6.3.3 For the total commercial book of business in this market, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above with 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 DM program based on Plan's criteria (NOT Prevalence). Refer back to Plan response in 6.2.1.

Starting at row 4, based on the Plan's stratification of members with CAD, indicate the types of interventions that are received by the population based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should 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 31st, 2014 who participated in the activity at any time during 2014. If participation rates provided are not market-specific - please note in detail box

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to CAD Patients in this state/market	Number of members in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)	Is Intervention standard or buy-up option (Cost of Intervention)	Risk strata that receives this intervention	Autocalculated % of HEDIS CAD eligible who received intervention	Autocalculated % of Plan CAD eligible 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 139-140 of the 2014 HEDIS Technical Specifications Vol 2.,	Decimal.						

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provide number of members 18 and above with CAD							
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in CAD DM program	<i>Decimal.</i>						
General member education (e.g., newsletters)		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered	<i>Decimal.</i> From 0 to 1000000000000000.	<i>Multi, Checkboxes.</i> 1: Included as part of CAD program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No CAD program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No CAD program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No CAD program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No CAD program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	<i>Multi, Checkboxes.</i> 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		AS ABOVE	<i>Decimal.</i> From 0 to 1000000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
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	<i>Decimal.</i> From 0 to 1000000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
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	<i>Decimal.</i> From 0 to 1000000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number provided, 6: Offered but not tracked regionally or nationally	<i>Decimal.</i> From 0 to 1000000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

Covered California

Self-initiated text/email messaging		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number provided, 6: Offered but not tracked regionally or nationally	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention.		AS ABOVE	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
IVR with outbound messaging only		AS ABOVE	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Live outbound telephonic coaching program (count only members that are successfully engaged)		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

8.6.3.4 For the total commercial book of business 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). **Refer back to Plan response in 6.2.1.**

Starting at Row 4, based on the Plan's stratification of members with Diabetes, indicate the types of interventions that are received by the population based on the level of risk segmentation. Enter "Zero" if the intervention is not provided to members with Diabetes. Select "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention. Select "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program. Select online interactive self management only if the application involves customized information based on branch logic. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include static web information. A member is "actively engaged" in the outbound telephonic program if they participate beyond the initial coaching call.

For member counts use the number of members as of December 31st, 2014 who participated in the activity at any time during 2014. **If participation rates provided are not market –specific – please note in detail box.**

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to Diabetes Patients in this state/market	Number of members 18 years and above in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)	Is intervention a standard or buy-up option (Cost of Intervention)	Risk strata that receives this intervention	Autocalculated % of HEDIS Diabetes eligible who received intervention	Autocalculated % of Plan Diabetes eligible who received intervention
Number of members aged 18 and above in this market	<i>Decimal.</i>						
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	<i>Decimal.</i>						
Using the plan's own criteria, provide number of members identified with condition and	<i>Decimal.</i>						

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eligible to participate in diabetes DM program							
General member education (e.g., newsletters)		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered	<i>Decimal.</i> From 0 to 100000000000.	<i>Multi, Checkboxes.</i> 1: Included as part of Diabetes program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No Diabetes program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No Diabetes program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No Diabetes program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No Diabetes program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	<i>Multi, Checkboxes.</i> 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		AS ABOVE	<i>Decimal.</i> From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
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	<i>Decimal.</i> From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
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	<i>Decimal.</i> From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)		<i>Multi, Checkboxes.</i> 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number provided, 6: Offered but not tracked regionally or nationally	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Self-initiated text/email messaging		AS ABOVE	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves information capture of		AS ABOVE	<i>Decimal.</i> From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

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member response information for record updates and/or triggering additional intervention.							
IVR with outbound messaging only		AS ABOVE	Decimal. From 0 to 10000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Live outbound telephonic coaching program (count only members that are successfully engaged)		Multi, Checkboxes. 1: HMO, 2: PPO, 3: Intervention not offered	Decimal. From 0 to 10000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

8.6.3.5 For the total commercial book of business in this market, 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 Applicant'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 31 who 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 Applicant offers intervention but does not track participation, enter zero)	Is intervention standard or buy-up option (Cost of Intervention)	Risk strata that receives this intervention	Autocalculated % of HEDIS 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.	Multi, Checkboxes. 1: Included as part of Asthma program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No Asthma program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No Asthma program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No Asthma program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No Asthma program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	Multi, Checkboxes 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		(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)

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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)
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Applicant 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 1000000000000000		Multi, Checkboxes. 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown
Self-initiated text/email messaging		(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)
IVR with outbound messaging only		(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)

8.6.3.6 If the plan indicates that it monitors services for gaps in CAD, diabetes and/or asthma in questions above (Q 6.3.3 and/or 6.3.4), indicate which services are monitored. If the "other" choice is selected, describe the service that is monitored in the text box. The Plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

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

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8.6.3.7 If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in the questions above (Q 6.3.3, 6.3.4 and/or 6.3.5), provide an actual, blinded copy of the reminders or telephone scripts as CC 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: CC 1a is provided - Coronary Artery Disease,
- 2: CC 1b is provided - Diabetes,
- 3: At Risk 1c is provided – Asthma
- 4: No support is provided

8.6.3.8 If online interactive self-management support is offered (response in Q 6.3.3, 6.3.4 and/or 6.3.5), provide screen prints or other documentation illustrating functionality as CC 2. Check the boxes below to indicate the disease states illustrated.

Multi, Checkboxes.

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

8.6.3.9 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, Plan DUR staff, etc.) Check all that apply.

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

	Drugs Monitored for Adherence	Entity responsible for monitoring and acting on medication adherence	Members monitored	Actions taken	Briefly describe role of plan in reminder/alert program	Other (describe)
CAD	Multi, Checkboxes. 1: Statins, 2: Beta Blockers, 3: Nitrates, 4: Calcium Channel blockers, 5: ACEs/ARBs, 6: Other (describe), 7: Compliance (medication refills) is not systematically assessed	Multi, Checkboxes. 1: Plan personnel, 2: PBM, 3: Retail or mail pharmacy, 4: Other (describe)	Single, Radio group. 1: All members taking the checked drugs are monitored, 2: Only DM participants are monitored	Multi, Checkboxes. 1: Member must activate reminders, 2: Member receives mailed reminders, 3: Member receives electronic reminder (e.g. email), 4: Member receives telephone contact, 5: Practitioner is mailed an alert, 6: Practitioner is contacted electronically, 7: Practitioner is contacted by telephone, 8: Telephonic coach is notified, 9: Gap in fills are communicated electronically to personal health record which will trigger a member alert, 10: Other (describe)	100 words.	100 words.
Diabetes	Multi, Checkboxes. 1: Statins, 2: Insulin, 3: Alpha-glucosidase, 4: Biguanides, 5: DPP-IV inhibitors, 6: Meglitinides, 7: Thiazolidine diones, 8: Sulfonylureas, 9: Other (describe), 10: Compliance (medication refills) is not systematically assessed	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma	Multi, Checkboxes. 1: Steroidal anti-inflammatories, 2: Non-steroidal anti-inflammatories, 3: Beta agonists (short and long-acting), 4: Xanthines, 5: Anti-cholinergics, 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

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

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

8.6.3.11 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 to the purchaser. 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 plan development, tracking, and follow-up, 6: Self-management skills, 7: Provider steering, 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

8.6.4 Performance Measurement: CAD and Diabetes

8.6.4.1 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2014 and QC 2013. The HEDIS measure eligible for rotation for QC 2014 is Cholesterol Management for Patients with Cardiovascular Conditions. Screening and Control rates for these measures must be rotated together.

If plan rotated Cholesterol Management for Patients with Cardiovascular Conditions for QC 2014, QC 2014 would be based on QC 2013, so the prior year data that would be uploaded would be QC 2012.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

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

This answer is supplied by Health Benefit Exchange (individually).

	HMO QC 2014	HMO QC 2013, or Prior Year Results for rotated measure
Controlling High Blood Pressure - Total	Percent. From -10 to 100.	Percent. From -10 to 100.
Persistence of Beta-Blocker treatment after a heart attack	Percent. From -10 to 100.	Percent. From -10 to 100.

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Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL) (Eligible for rotation in QC 2014)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening (Eligible for rotation in QC 2014)	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.

8.6.4.2 PPO version of above.

8.6.4.3 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2014 and QC 2013. The HEDIS measures eligible for rotation for QC 2014 are any Comprehensive Diabetes Care measure. Note that the screening and control rates for these measures must be rotated together. The HbA1c Control <7% for a Selected Population indicator must be rotated with all the other HbA1c indicators in the CDC measure.

If plan rotated any of the Comprehensive Diabetes Care Measures for QC 2014, QC 2014 would be based on QC 2013, so the prior year data that would be uploaded would be QC 2012.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

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

This answer is supplied by **Health Benefit Exchange** (individually).

	HMO QC 2014 results	HMO QC 2013 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Comprehensive Diabetes Care - HbA1c Testing	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - LDL-C Screening	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Medical Attention for Nephropathy	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 8%	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 7% for a Selected Population	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - LDL-C Controlled (LDL-C<100 mg/dL)	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	AS ABOVE.	AS ABOVE

8.6.4.4 PPO version of above.

8.6.5 Plan Organization for Behavioral Health Management

8.6.5.1 Identify how members are able to access BH services. Check all that apply.

Multi, Checkboxes.

- 1: BH practitioners are listed in the Plan's print/online directory,
- 2: Members call the Plan to identify an appropriate practitioner,
- 3: Members call the MBHO to identify an appropriate practitioner,
- 4: Members call the BH practitioner office directly,

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- 5: Other (describe in detail box below),
- 6: Not applicable/all BH services are carved out by the employers

8.6.5.2 What provisions are in place for members who contact the Plan's published BH service access line (member services or BH/MBHO department directly) for emergent BH services after regular business hours? For access to Behavioral Health clinical services, a "warm transfer" is defined as a telephone transfer by a Plan representative where the Plan representative ensures the member is connected to a live voice in the Behavioral Health Department or at the Behavioral Health vendor without interruption or the need to call back. Check all that apply.

Multi, Checkboxes.

- 1: Members reach a BH clinician directly,
- 2: Members reach a live response from a nurse or other triage trained individual and receive a warm transfer to a BH clinician,
- 3: Members reach an answering service or a message that provides the opportunity to receive a return call or to page a BH clinician,
- 4: Other (describe in detail box below);
- 5: Not applicable/all BH services are carved out

8.6.5.3 Purchasers are interested in Plan activities in alcohol and depression screening and interventions. Indicate the scope of the Plan's Alcohol Use Disorder and Depression Programs. Alcohol screening is defined as the use of a valid questionnaire about the context, frequency and amount of an individual's alcohol use. Screening offers a reliable, inexpensive and quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one. Check all that apply.

If response options # 3 (All members actively involved in other disease management or case management programs) and # 4 (All members with targeted chronic disease conditions regardless of prior DM or case management program involvement (medium or low risk) are selected - please describe in following column.

If "program not available" is selected for all rows the following question asking about reach of programs will not be answerable

	Response	Description of programs and/or targeted conditions (response options 3, 4 or 7 from previous column)
Alcohol Screening	<p>Multi, Checkboxes.</p> <p>1: All members involved in the Plan's high risk pregnancy program,</p> <p>2: All members who are pregnant (discovered through precertification, claims scanning, medical records),</p> <p>3: All members actively involved in other disease management or case management programs,</p> <p>4: All members with targeted chronic disease conditions regardless of prior DM or case management program involvement (medium or low risk),</p> <p>5: All members with medical record or claims indications of alcohol use or depression (e.g. antidepressant Rx),</p> <p>6: All members (e.g. monitoring and following up on screening tools in medical record),</p> <p>7: Other,</p> <p>8: Program not available</p>	100 words.
Alcohol Use Disorder Management	AS ABOVE.	65 words.
Depression Screening	AS ABOVE.	65 words.
Depression Management	AS ABOVE.	65 words.

8.6.5.4 For the commercial book of business, indicate the reach of the Plan's behavioral health screening and management program. If condition is only managed as a comorbidity within another program, the Plan should indicate the condition is managed only as a comorbidity and identify (as text in the last column) the primary condition(s) linked to the comorbidity. The distinction "available to all" versus "an option to purchase" should be provided only for these primary managed conditions where the Plan proactively identifies all members with the condition for program interventions - not just among these who have been identified with another condition (not comorbidity managed conditions). If the program is administered fully or jointly indicate the vendor name.

Alcohol screening is defined as the use of a valid questionnaire about the context, frequency and amount of an individual's alcohol use. Screening offers a reliable, inexpensive and quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one.

If response for column "Reach of Programs" differs based on product offered (HMO versus PPO) and plan is responding for BOTH products - please select the option that covers most of the membership (most common) and note the other in the additional information section.

Note that your response about geography of reach of programs in first column should correspond to your response to questions 6.6.1 and 6.6.2

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	Reach of Programs	Cost of Program availability	1. Vendor Name if plan outsources or jointly administers, 2. Primary condition if managed as co-morbidity
Alcohol Screening	<i>Single, Radio group.</i> 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Program not available in any market	<i>Multi, Checkboxes.</i> 1: Plan-wide, condition-specific and available to all fully insured members as described in question above as part of standard premium, 2: Plan-wide, condition-specific and available to all self-insured members as described in question above as part of standard ASO fee with no additional fee assessed, 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members.	50 words.
Alcohol Use Disorder Management	AS ABOVE	AS ABOVE	50 words.
Depression Screening	AS ABOVE	AS ABOVE.	50 words.
Depression Management	AS ABOVE	AS ABOVE	50 words.

8.6.6 Member Screening & Support in Behavioral Health

8.6.6.1 If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in question 6.6.2 above, provide an actual, blinded copy of the reminder as CC 4. If the reminder does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service, 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. If the plan indicates that it monitors services for gaps, indicate which services are monitored. If the "other" choice is selected, describe the service that is monitored in the text box. The Plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

Multi, Checkboxes.
1: CC 4a is provided - Behavioral health,
2: CC 4b is provided - Substance use,
3: Not provided

8.6.6.2 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, Plan DUR staff, etc.) Check all that apply.

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

	Drugs that are monitored for adherence	Entity responsible for monitoring and acting on adherence	Members monitored	Actions taken	Briefly describe role of Plan in Reminder/Alert Program	Other (describe) Action Taken and/or Responsible Party
Behavioral Health	<i>Multi, Checkboxes.</i> 1: Antidepressants, 2: Atypical antipsychotics, 3: Other (describe), 4: Compliance (medication refills) is not systematically assessed	<i>Multi, Checkboxes.</i> 1: Plan personnel, 2: PBM, 3: Retail or mail pharmacy, 4: Other (describe)	<i>Single, Radio group.</i> 1: All members taking the checked drugs are monitored, 2: Only DM participants are monitored	<i>Multi, Checkboxes.</i> 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.
Substance Use Disorders	AS ABOVE	AS ABOVE	AS ABOVE monitored	AS ABOVE	100 words.	100 words.

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8.6.7 Performance Measurement: Behavioral Health

8.6.7.1 Review the two most recently calculated years of HEDIS results for the Plan's HMO Product. Measures not eligible for rotation in QC 2014. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	QC 2014 result	QC 2013 result
Identification of Alcohol & Other Drug Dependence Services - % Members Receiving Any Services	Percent. From -10 to 100.	Percent. From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	Percent. From -10 to 100.	Percent. From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	Percent. From -10 to 100.	Percent. From -10 to 100.

8.6.7.2 PPO version of above.

8.6.7.3 Review the two most recently calculated years of HEDIS results for the Plan's HMO product. Measures not eligible for rotation in QC 2014. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	QC 2014 result	QC 2013 result
Mental Health Utilization - % Members Receiving Services - Any	Percent. From -10 to 100.	Percent. From -10 to 100.
FU After Hospitalization For Mental Illness - 7 days	Percent. From -10 to 100.	Percent. From -10 to 100.
FU After Hospitalization For Mental Illness - 30 days	Percent. From -10 to 100.	Percent. From -10 to 100.
Antidepressant Medication Management - Effective Acute Phase Treatment	Percent. From -10 to 100.	Percent. From -10 to 100.
Antidepressant Medication Management - Effective Continuation Phase Treatment	Percent. From -10 to 100.	Percent. From -10 to 100.
FU Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	Decimal. From -10 to 100.	Decimal. From -10 to 100.
FU Care for Children Prescribed ADHD Medication - Initiation	Decimal. From -10 to 100.	Decimal. From -10 to 100.

8.6.7.4 PPO version of above.

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8.6.8 Performance Measurement: Other Conditions

8.6.8.1 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2014 and QC 2013. This was not a rotated measure.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	HMO QC 2014	HMO QC 2013
COPD: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Percent. From -10 to 100.	Percent. From -10 to 100.

8.6.8.2 PPO version of above.

8.6.8.3 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2014 and QC 2013. This was not a rotated measure.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by **Health Benefit Exchange** (individually).

	HMO QC 2014	HMO QC 2013
Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	Percent. From -10 to 100.	Percent. From -10 to 100.
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	Percent. From -10 to 100.	Percent. From -10 to 100.

8.6.8.4 PPO version of above.

8.6.9 Other Information Chronic Conditions

8.6.9.1 If the Plan would like to include additional information about helping members manage chronic conditions that was not reflected in this section, provide as CC 5.

Single, Pull-down list.

- 1: CC 5 is provided with a 4 page limit,
- 2: Not provided

8.7 PHARMACEUTICAL MANAGEMENT

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8.7.1 Instructions and Definitions

8.7.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2015 eValue8 RFI. The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.

8.7.1.2 All attachments to this module must be labeled as "Pharmacy #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Pharmacy 1a, Pharmacy 1b, etc.

8.7.1.3 Pharmacy Benefit Manager is abbreviated as "PBM" throughout this form. **If the Plan contracts with a PBM, the Plan is strongly encouraged to work collaboratively with the PBM in the completion of this form.**

8.7.1.4 **All questions refer to the Plan's commercial membership. Membership of commercial customers that have removed pharmacy management from the Plan (carved-out) and directly contracted with a separate PBM should be excluded from all responses and calculations.**

8.7.1.5 All responses for the 2015 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2015 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

8.7.1.6 **Plan activities must be in place by the date of this RFI submission for credit to be awarded.**

8.7.2 Value-Based Formulary

8.7.2.1 Has the Plan developed a "value-based" formulary for use by purchasers that ranks pharmaceuticals ACROSS DRUG CLASSES by clinical importance and effectiveness? (This is different from the Plan's decision process of the pharmacy and therapeutics committee to determine which drugs are placed on formulary. By this definition the Plan must have considered the relative criticality of drugs between drug classes and introduced copays or coinsurance designs that make some brand drugs available on the lowest cost tier for "essential" drug classes regardless of availability of generic and/or OTC medications to make substantial use of brand drugs necessary to accommodate member needs.). If the Plan has developed a value-based formulary as defined above, describe in the Detail text box the following: process and sources for determining its content and structure, the purchaser name(s) and the market if this is a pilot. If this was a pilot the previous year, please provide a brief update in detail box.

Single, Pull-down list.

- 1: Yes, and the ranking is tied to a variable copay design available in this market,
- 2: Yes, and the ranking is tied to a variable copay design being piloted,
- 3: Yes, but there is currently no link to a variable copay design,
- 4: An evidence-based formulary is under development,
- 5: No

8.7.3 Generic & Appropriate Drug Use

8.7.3.1 Does the Plan employ any of the following strategies (defined below) to address cost management or appropriateness of utilization?

Therapeutic class reference pricing defined as: assigning a maximum allowable cost for the lowest cost drug among therapeutically equivalent drugs. For therapeutic class MAC strategies, the member or physician group at risk, etc. would bear the cost differential of the higher priced drug, if he/she chose to ignore the lower cost recommendation.

Therapeutic Interchange: defined as substitution of therapeutically equivalent drugs at the point of service or in a subsequent refill after physician consultation.

Prior Authorization defined as a requirement that the Practitioner receive authorization from the Plan before the drug can be dispensed.

Step therapy is used in cases where there may be some patient-specific advantages to one brand drug compared to another or to a generic, and is defined as a requirement that the appropriate, usually less expensive drugs be tried first to determine efficacy before converting to a higher priced drug in the same class.

Dose Optimization defined as requiring that single dose-alternatives be used instead of multiple doses per day where single doses are possible.

Multi, Checkboxes.

- 1: Therapeutic Class reference Pricing,
- 2: Therapeutic Interchange,
- 3: Prior Authorization,

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- 4: Step Therapy,
- 5: Dose Optimization,
- 6: Pill Splitting,
- 7: Mandatory mail order refills for chronic drug therapy after 2nd, 3rd or 4th fill of 30 day quantity at a community/retail pharmacy,
- 8: Partial fill dispensing for specialty medications with patient follow-up,
- 9: Other (describe in detail box below),
- 10: None of the Above

8.7.3.2 For HMO, provide the Plan's **aggregate generic dispensing rate** (% of total prescriptions that were filled with a generic drug, regardless of whether a generic was available), excluding injectables. The Plan should report the strict definition of "generic" provided by a nationally recognized and accepted source (i.e. First DataBank or Medispan). Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and **round up** to convert. For example, a 100 day prescription is equal to 4 dispensing events ($100/30 = 3.33$, rounded up to 4). **If the Plan has a policy of covering prescription and/or OTC brand drugs where the generic drug is more expensive, indicate in the "Adj Answer" row the dispensing rate adding those fills to the numerator and denominator.**

HMO Response	2014 Percent for this market/state	2013 Percent for this market/state	2014 Percent for the nation	2013 Percent for the nation
Aggregate Generic Dispensing Rate	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> N/A OK. From 0 to 100.00.	<i>Percent.</i> N/A OK.
Adj Answer	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i> N/A OK.	<i>Percent.</i> N/A OK.

8.7.3.3 PPO version of above.

8.7.3.4 For the HMO, provide the requested rates as defined below. Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round up to convert. For example, a 100 day prescription is equal to 4 dispensing events ($100/30 = 3.33$, rounded up to 4).

HMO Response	Rx program in Market/State?	Market/State 2014 rate	Market/State 2013 rate	Rx program in nation?	National 2014 rate	National 2013 rate
Generic ACE inhibitors (ACE and ACE with HCTZ)/(ACE + ARBs (angiotensin II receptor antagonists)) Include ACE and ARB drugs that are dispensed as combination drugs in the denominator (i.e., ACE, ACE combinations (HCTZ or other agents), ARB and ARB combinations (HCTZ or other agents))	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.
Generic PPIs +OTC PPIs / (All PPIs INCLUDING OTC PPIs)	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.
Generic STATINS/(ALL Cholesterol lowering agents) Cholesterol lowering agents : statins (and statin combinations e.g., atorvastatin/amiodipine combination), bile acid binding resins (e.g., cholestyramine, colestipol and colesevelam), cholesterol absorption inhibitors and combinations (ezetimibe and ezetimibe/simvastatin), fibrates (fenofibrate and gemfibrozil), Niacin (vitamin B-3, nicotinic acid) and niacin/lovastatin combination. IF ezetimibe/simvastatin is counted in statin combination - DO NOT COUNT again under ezetimibe combination.	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> From -10 to 100.	<i>Percent.</i>	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.
Generic metformin/all oral anti diabetics, including all forms of glucophage	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.
Generic SSRIs/all SSRI antidepressants	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.	<i>Single, Radio group.</i> 1: Yes, 2: No	<i>Percent.</i> N/A OK. From 0 to 100.	<i>Percent.</i> N/A OK.

8.7.3.5 PPO version of above.

8.7.3.6 Review the overall rate of antibiotic utilization from HEDIS QC 2014. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result

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in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by Health Benefit Exchange (individually).

	QC 2014 (HMO)
Average number of antibiotic scripts PMPY	Decimal.
Average days supplied per antibiotic script	Decimal.
Average number of scripts PMPY for antibiotics of concern	Decimal. From -10 to 100.
Percentage of antibiotics of concern out of all antibiotic scripts	Percent. From -10 to 100.

8.7.3.7 PPO version of above.

8.7.4 Specialty Pharmaceuticals

8.7.4.1 Purchasers have an increasing interest in the prevalence of use and cost of specialty medications and biologics. (See attached list defining specialty pharmaceuticals (SP) and formulations for use in this section). If any drugs on the attached list are not addressed in your program, list them in the "detail description" text box and indicate why they are not included.

For total spend in calendar year 2014, and using only the specialty pharmaceuticals (SPs) in the attached list, please provide estimates of the percent spent on SPs (versus overall), self-administered medications, and percent reimbursed through the medical benefit. Describe below the plan's (1) current strategy, activities and programs implemented to manage specialty pharmaceuticals & biologics in 2014. (2) Please outline any changes planned for 2015. (3) If plan uses a specialty vendor, please describe their strategy and provide their name.

Does plan use a specialty vendor? If yes provide name	50 words.
Estimate the % of specialty drug spend out of all drug spend (denominator = total \$ drug spend including specialty drug \$)	Percent. N/A OK. From 0 to 100.
Estimate the % of specialty pharmacy drug spend that is reimbursed under the medical benefit	Percent. N/A OK. From 0 to 100.
Estimate the % of specialty drug spend that is self-administered	Percent. N/A OK. From 0 to 100.
Current strategy, activities or programs to manage specialty medicines and biologics	200 words.
Changes planned in following year	100 words.

8.7.4.2 Indicate if the Plan implemented one or more of the following programs to address specialty pharmaceuticals (SP) defined in attached list in 7.4.1. Check all that apply.

Program (Specialty Pharmaceuticals)	Answer	Describe Program (and tiering)
Use of formulary tiers or preferred/non-preferred status (if yes, please describe in last column what tier or status you typically use for the drugs listed)	Single, Radio group. 1: Yes, 2: No	65 words.

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Utilization Management		
Prior authorization	AS ABOVE	AS ABOVE
Step edits	AS ABOVE	AS ABOVE
Quantity edits/limits	AS ABOVE	AS ABOVE
Limits on off label use	AS ABOVE	AS ABOVE
Split fill (Specialty Pharmacy sends 14 Day quantity, then checks up on patients side effects, adherence, and sends another 14 days –at least for the 1ST month)	AS ABOVE	AS ABOVE
Use of Genomic Test to assess appropriateness or effectiveness of medication in particular patient	AS ABOVE	AS ABOVE
Channel Management (limiting dispensing to specific providers)	AS ABOVE	AS ABOVE
Reimbursement Reductions (reimbursing physicians, PBM, pharmacies according to a fixed fee schedule)	AS ABOVE	AS ABOVE
None of the above	AS ABOVE	

8.7.4.3 Does the Plan allow an employer the option to allow physician administered products to be delivered via the pharmacy benefit versus medical benefit? If YES, please detail below how Plan would do this for chemotherapy administered directly by physicians

Single, Radio group.

1: Yes,
2: No

8.7.4.4 For the listed conditions associated with SP drugs, indicate how these conditions are managed.

Condition	Management	Details (description of "other" or the main condition)
Rheumatoid Arthritis	<i>Multi, Checkboxes.</i> 1: Managed by DM/ Care management program if it is the sole condition, 2: Managed by DM/ Care management program only if a comorbidity with another condition (e.g. diabetes), (name the condition in the next column), 3: Internally Managed as part of SP program independent of the DM/ Care management program, 4: Managed by SP vendor independent of the DM/ Care management program, 5: Member compliance with SP drugs is monitored through refill claims and made available to care managers, 6: Not managed by either DM or SP program, 7: Integrated and managed as part of patient centered care (describe), 8: Other (describe in next column)	65 words.
Multiple Sclerosis	AS ABOVE	AS ABOVE
Oncology	AS ABOVE	AS ABOVE
Hepatitis C	AS ABOVE	AS ABOVE
HIV	AS ABOVE	AS ABOVE
Hemophilia	AS ABOVE	AS ABOVE
Growth Hormone Deficiency	AS ABOVE	AS ABOVE

8.7.4.5 Using only the drugs identified in the list attached to question 7.4.1 and their condition associations (e.g. hepatitis C), for your total commercial book of business, provide the TOTAL cost per member per month (PMPM) for SP/biotech pharmaceuticals including acquisition, administration fees and member copayments BUT net of rebates, and discounts.

Drug Class	2014 PMPM Cost	2013 PMPM Cost

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TNF Inhibitors	<i>Dollars.</i> N/A OK. From 0 to 1000000000.	<i>Dollars.</i> N/A OK.
ESAs excluding dialysis medications	AS ABOVE	AS ABOVE
WBC Growth Factors	AS ABOVE	AS ABOVE
MS Drug Therapies	AS ABOVE	AS ABOVE
Hepatitis C Drug Therapies	AS ABOVE	AS ABOVE
Oral oncolitics	AS ABOVE	AS ABOVE
Office-administered drugs	AS ABOVE	AS ABOVE
ALL the drugs in the SP list	AS ABOVE	AS ABOVE

8.7.5 Quality and Safety: Outpatient Prescribing

8.7.5.1 Review HEDIS scores for the indicators listed.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

- 1 means 'NR'
- 2 means 'NA'
- 3 means 'ND'
- 4 means 'EXC' and
- 5 means 'NB'

Please refer to the attached document for an explanation of terms

This answer is supplied by Health Benefit Exchange (individually).

	HEDIS QC 2014 (HMO)	HEDIS QC 2013 (HMO)
Appropriate treatment for children with upper respiratory infection	<i>Percent.</i> From -10 to 100.	<i>Percent.</i> From -10 to 100.
Appropriate testing for children with pharyngitis	AS ABOVE	AS ABOVE
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	AS ABOVE	AS ABOVE
Use of Appropriate Medications for People with Asthma - Total	AS ABOVE	AS ABOVE
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Digoxin	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Diuretics	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Total	AS ABOVE	AS ABOVE

8.7.5.2 PPO version of above.

8.7.5.3 For persons with asthma on medication therapy, purchasers expect plans to monitor and identify those who are not controlled optimally and/or not on controller therapy. Please see the attachment for the Pharmacy Quality Alliance (PQA) approved definitions to respond to question on

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suboptimal control and absence of controller therapy (pages 4, 8, 30-32). The NDCs list excel workbook attachment can be found in "Manage Documents": NDC List 6_28_2014 NBCH Customized. Please refer to the "Respiratory" tab in the excel document.

This question is flagged "Regional." Statewide carriers - if plan provided a statewide response - please note this in detail box below.

Description	Rate (HMO regional Response)	Rate (PPO Regional Response)
Suboptimal Control: The percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.	<i>Percent.</i> N/A OK. From -10 to 100.	<i>Percent.</i> N/A OK. From -10 to 100.
Absence of Controller Therapy: The percentage of patients with asthma during the measurement period who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.	<i>Percent.</i> N/A OK. From -10 to 100.	<i>Percent.</i> N/A OK. From -10 to 100.

8.7.6 Other Information

8.7.6.1 If the Plan would like to provide additional information about the pharmacy program that was not reflected in this section, provide as Attachment Pharmacy 1.

Pharmacy 1 is provided.

Single, Pull-down list.

1: Yes with a 4 page limit,
2: No

8.8 CLIENT SUPPORT, DATA ANALYSES AND REPORTING

8.8.1 Beneficiary Communication and Benefit Design

8.8.1.1 Indicate the beneficiary communication and outreach support offered to the Plan's Purchaser customers. **For programs, address communication about the existence of member support tools and how to access and use them, not the communication that takes place within each program.**

Examples of on-site services include member enrollment support or product demonstrations at employee health fairs or open enrollment meetings. Check all that apply. "Pharmaceutical decision support information" is meant to indicate ongoing member support services such as online information (e.g., drug dictionaries, generic equivalents, etc.), general information mailings or targeted member mailings, (e.g., targeted mailings to members who may be taking a brand drug that is coming off-patent identifying available alternatives).

Program area	Type of support (for fully insured lives/plan)	Type of support (for self insured lives/plan)
Prevention/health/wellness materials that include content about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with \$0 cost share under the ACA	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available
Prevention/health/wellness biometric testing	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Support not available	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Support not available
Chronic condition management program information	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge,	Multi, Checkboxes. 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge,

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	7: Standard written communications, 8: Support not available	7: Standard written communications, 8: Support not available
Practitioner/Hospital selection/comparison information	AS ABOVE	AS ABOVE
Pharmaceutical decision support information	AS ABOVE	AS ABOVE
Treatment option decision support information	AS ABOVE	AS ABOVE
Personal health record information	AS ABOVE	AS ABOVE
Price comparison information	AS ABOVE	AS ABOVE
Engaging employees to access PCP, PCMH and/or ACO Providers	AS ABOVE	AS ABOVE
Engaging employees with limited English	AS ABOVE	AS ABOVE
Engaging employees of particular cultural groups	AS ABOVE	AS ABOVE
Engaging employees with limited health literacy	AS ABOVE	AS ABOVE

8.8.1.2 Evidence is emerging that suggests better alignment of consumer incentives through plan design will result in improved plan performance. Examples of this type of alignment include removal or reduction of financial barriers to essential treatments, using comparative evidence analysis to provide a graded scale of copays reflecting the importance/impact of specific treatments, premium reduction or other incentives for members that use higher performing providers (physicians and hospitals), or follow preventive and/or chronic disease management guidelines, etc.

Please describe any efforts that the Plan is currently undertaking or planning for the future. List any limitations in this market on the geographic availability of pilots, incentive designs or high performance networks.

200 words.

8.8.2 Data Analyses and Reporting

8.8.2.1 For the book of business represented by this RFI response and supported by the attachment(s) labeled as Client 1 in question below, indicate (1) the types of data analyses and reporting available to employers and/or their designated vendors on health management and chronic conditions, and (2) the sources of data used to generate the types of analyses and reports available to Employers. Purchasers expect plans to help assess and improve health status of their Employees using a variety of sources. Check all that apply. **If reports are not part of the standard premium or ASO fee, plans should also select response that says "Report available for additional fee."**

	Report Features for Fully Insured Lives/Plan	Report Features for Self Insured Lives/Plan	Sources of Data
Chronic Condition Prevalence	<i>Multi, Checkboxes.</i> 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 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	<i>Multi, Checkboxes.</i> 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 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	<i>Multi, Checkboxes.</i> 1: HRAs, 2: Medical Claims Data, 3: Pharmacy Claims Data, 4: Lab Values, 5: Other source - please detail below
Employee Population stratified by Risk and/or Risk Factors	AS ABOVE	AS ABOVE	AS ABOVE
Chronic Condition/Disease	AS ABOVE	AS ABOVE	AS ABOVE

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Management (DM) program enrollment			
Change in compliance among DM enrollees (needed tests, drug adherence)	AS ABOVE	AS ABOVE	AS ABOVE
Health status change among DM enrollees	AS ABOVE	AS ABOVE	AS ABOVE

8.8.2.2 Attachments are needed to support plan responses to the question above. Provide as Client 1, 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 plan response).

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

For example if plan responds that they can provide group specific results (response option 1) with comparison benchmarks of similarly sized groups are available with trend comparison data of two years rolling and fixed for parameters in first 3 rows (**chronic disease prevalence, Employee 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 employee 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

Single, Radio group.

- 1: Client 1 is provided,
- 2: Not provided

9. SHOP SUPPLEMENTAL APPLICATION

9.1 Applicant must identify the individual(s) who will function as the Exchange's primary contact for SHOP products.

- Name
- Title
- Department
- Phone
- Fax
- E-mail

9.2 In addition to standardized benefit design products, the Applicant may submit up to two (2) alternate benefit design products for the rating region. Alternate benefit designs are optional.

Applicants are not required to offer alternate benefit designs in order to participate in SHOP. Alternate benefit designs must comply with state statutory and regulatory requirements. If two plans are proposed, the plans should be of different metal tiers. Any alternate benefit design must represent a product family using the same network across all actuarial values. The alternate benefit design offering should incorporate the standard composite calculation process utilized for all SHOP plans.

Use Attachment G (SHOP Alternate Plan Design) to submit all cost sharing and other details for proposed alternate benefit plan designs. The Exchange is not necessarily encouraging alternate benefit plan designs and will carefully scrutinize such proposals.

- Yes, proposing alternate benefit design
- No, not proposing alternate benefit design

If yes, complete Attachment G SHOP (Alternate Plan Design) to indicate benefits and member cost sharing design for each alternate benefit plan design you propose. In completing the matrix, Applicant may insert text to:

- Indicate any additional or enhanced benefits relative to EHB
- Confirm all plans include pediatric oral and vision EHB
- If in-network tiers are proposed, describe the structure for hospital or provider tiers.

9.3 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the 12-month-period subsequent to the initial effective dates for all employer groups whose initial effective dates are between January 1, 2016 and December 31, 2016. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies in conjunction. Premium bids are due May 1, 2015. To submit premium proposals for SHOP products, QHP applicants will complete and upload through the System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT) and the Rates Template located at: http://www.serff.com/plan_management_data_templates.htm. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange's request, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

9.4 Quality Improvement

9.4.1 Complete the following table to provide additional detail regarding member incentives available in SHOP Exchange.

Preventive and Wellness Services	Available in SHOP Exchange	SHOP Exchange Financial Incentives	SHOP Exchange Financial Incentives
Incentives Contingent	Yes/No	Yes/No	<p><i>Multi, Checkboxes.</i></p> <p>1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced employee premium share and increased employer premium share contingent upon completion/participation. Health Plan premium rates remain unchanged, 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</p>
Health Assessment Offered	AS ABOVE	AS ABOVE	
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	
Tobacco Cessation Program	AS ABOVE	AS ABOVE	
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Stress Management	AS ABOVE	AS ABOVE	
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Mental Health	AS ABOVE	AS ABOVE	
OTHER	AS ABOVE	AS ABOVE	

Appendix B: Geographic Areas with Fewer than Three Plan Choices in 2015

Rating Region	County	Zip Code
Zip codes with one (1) plan choice		
Region 1	ALPINE	95646
Region 1	ALPINE	96120
Region 1	AMADOR	95629
Region 1	AMADOR	95644
Region 1	AMADOR	95666
Region 1	AMADOR	95689
Region 1	BUTTE	95901
Region 1	BUTTE	95914
Region 1	BUTTE	95925
Region 1	BUTTE	95930
Region 1	BUTTE	95941
Region 1	BUTTE	95942
Region 1	CALAVERAS	95223
Region 1	CALAVERAS	95224
Region 1	CALAVERAS	95228
Region 1	CALAVERAS	95229
Region 1	CALAVERAS	95230
Region 1	CALAVERAS	95232
Region 1	CALAVERAS	95233
Region 1	CALAVERAS	95236
Region 1	CALAVERAS	95245
Region 1	CALAVERAS	95247
Region 1	CALAVERAS	95248
Region 1	CALAVERAS	95251
Region 1	CALAVERAS	95254
Region 1	CALAVERAS	95255
Region 1	CALAVERAS	95257
Region 1	COLUSA	95939
Region 1	COLUSA	95955
Region 1	COLUSA	95957
Region 1	COLUSA	95979
Region 1	COLUSA	95987

Covered California

Region 1	DEL NORTE	95543
Region 1	DEL NORTE	95548
Region 1	GLENN	95920
Region 1	GLENN	95939
Region 1	GLENN	95951
Region 1	GLENN	95963
Region 1	HUMBOLDT	95514
Region 1	HUMBOLDT	95526
Region 1	HUMBOLDT	95528
Region 1	HUMBOLDT	95546
Region 1	HUMBOLDT	95549
Region 1	HUMBOLDT	95550
Region 1	HUMBOLDT	95552
Region 1	HUMBOLDT	95554
Region 1	HUMBOLDT	95555
Region 1	HUMBOLDT	95556
Region 1	HUMBOLDT	95558
Region 1	HUMBOLDT	95565
Region 1	HUMBOLDT	95569
Region 1	HUMBOLDT	95570
Region 1	HUMBOLDT	95571
Region 1	HUMBOLDT	95573
Region 1	HUMBOLDT	95589
Region 1	LAKE	95423
Region 1	LAKE	95469
Region 1	LASSEN	96006
Region 1	LASSEN	96009
Region 1	LASSEN	96056
Region 1	LASSEN	96068
Region 1	LASSEN	96109
Region 1	LASSEN	96113
Region 1	LASSEN	96114
Region 1	LASSEN	96117
Region 1	LASSEN	96119
Region 1	LASSEN	96121
Region 1	LASSEN	96123
Region 1	LASSEN	96128

Covered California

Region 1	LASSEN	96132
Region 1	LASSEN	96136
Region 1	MENDOCINO	95410
Region 1	MENDOCINO	95415
Region 1	MENDOCINO	95417
Region 1	MENDOCINO	95425
Region 1	MENDOCINO	95427
Region 1	MENDOCINO	95428
Region 1	MENDOCINO	95429
Region 1	MENDOCINO	95432
Region 1	MENDOCINO	95445
Region 1	MENDOCINO	95449
Region 1	MENDOCINO	95454
Region 1	MENDOCINO	95459
Region 1	MENDOCINO	95463
Region 1	MENDOCINO	95466
Region 1	MENDOCINO	95468
Region 1	MENDOCINO	95469
Region 1	MENDOCINO	95488
Region 1	MENDOCINO	95494
Region 1	MENDOCINO	95585
Region 1	MENDOCINO	95587
Region 1	MENDOCINO	95589
Region 1	MODOC	96006
Region 1	MODOC	96015
Region 1	MODOC	96054
Region 1	MODOC	96056
Region 1	MODOC	96108
Region 1	MODOC	96110
Region 1	MODOC	96112
Region 1	MODOC	96116
Region 1	MODOC	96134
Region 9	MONTEREY	93426
Region 9	MONTEREY	93450
Region 9	MONTEREY	93451
Region 9	MONTEREY	93901
Region 9	MONTEREY	93902
Region 9	MONTEREY	93905
Region 9	MONTEREY	93906

Covered California

Region 9	MONTEREY	93907
Region 9	MONTEREY	93908
Region 9	MONTEREY	93912
Region 9	MONTEREY	93915
Region 9	MONTEREY	93920
Region 9	MONTEREY	93921
Region 9	MONTEREY	93922
Region 9	MONTEREY	93923
Region 9	MONTEREY	93924
Region 9	MONTEREY	93925
Region 9	MONTEREY	93926
Region 9	MONTEREY	93927
Region 9	MONTEREY	93928
Region 9	MONTEREY	93930
Region 9	MONTEREY	93932
Region 9	MONTEREY	93933
Region 9	MONTEREY	93940
Region 9	MONTEREY	93942
Region 9	MONTEREY	93943
Region 9	MONTEREY	93944
Region 9	MONTEREY	93950
Region 9	MONTEREY	93953
Region 9	MONTEREY	93954
Region 9	MONTEREY	93955
Region 9	MONTEREY	93960
Region 9	MONTEREY	93962
Region 9	MONTEREY	95004
Region 9	MONTEREY	95012
Region 9	MONTEREY	95039
Region 9	MONTEREY	95076
Region 1	NEVADA	95602
Region 1	NEVADA	95728
Region 1	NEVADA	95959
Region 1	NEVADA	95960
Region 1	NEVADA	95977
Region 1	NEVADA	95986
Region 1	NEVADA	96162
Region 1	PLUMAS	95915
Region 1	PLUMAS	95947
Region 1	PLUMAS	95980

Covered California

Region 1	PLUMAS	95981
Region 1	PLUMAS	95983
Region 1	PLUMAS	96135
Region 9	SAN BENITO	93210
Region 9	SAN BENITO	93930
Region 9	SAN BENITO	95004
Region 9	SAN BENITO	95043
Region 1	SHASTA	96008
Region 1	SHASTA	96011
Region 1	SHASTA	96013
Region 1	SHASTA	96017
Region 1	SHASTA	96022
Region 1	SHASTA	96033
Region 1	SHASTA	96040
Region 1	SHASTA	96047
Region 1	SHASTA	96051
Region 1	SHASTA	96056
Region 1	SHASTA	96059
Region 1	SHASTA	96062
Region 1	SHASTA	96065
Region 1	SHASTA	96069
Region 1	SHASTA	96070
Region 1	SHASTA	96071
Region 1	SHASTA	96076
Region 1	SHASTA	96084
Region 1	SHASTA	96088
Region 1	SHASTA	96096
Region 1	SIERRA	95960
Region 1	SIERRA	96118
Region 1	SIERRA	96124
Region 1	SIERRA	96126
Region 1	SISKIYOU	95568
Region 1	SISKIYOU	96014
Region 1	SISKIYOU	96023
Region 1	SISKIYOU	96027
Region 1	SISKIYOU	96031
Region 1	SISKIYOU	96032
Region 1	SISKIYOU	96034

Covered California

Region 1	SISKIYOU	96037
Region 1	SISKIYOU	96039
Region 1	SISKIYOU	96044
Region 1	SISKIYOU	96050
Region 1	SISKIYOU	96057
Region 1	SISKIYOU	96058
Region 1	SISKIYOU	96064
Region 1	SISKIYOU	96085
Region 1	SISKIYOU	96086
Region 1	SISKIYOU	96091
Region 1	SISKIYOU	96094
Region 1	SISKIYOU	96134
Region 1	SUTTER	95948
Region 1	SUTTER	95953
Region 1	SUTTER	95957
Region 1	SUTTER	95982
Region 1	SUTTER	95991
Region 1	SUTTER	95992
Region 1	SUTTER	95993
Region 1	TEHAMA	95963
Region 1	TEHAMA	96021
Region 1	TEHAMA	96022
Region 1	TEHAMA	96029
Region 1	TEHAMA	96059
Region 1	TEHAMA	96061
Region 1	TEHAMA	96063
Region 1	TEHAMA	96074
Region 1	TEHAMA	96075
Region 1	TEHAMA	96076
Region 1	TEHAMA	96092
Region 1	TRINITY	95526
Region 1	TRINITY	95527
Region 1	TRINITY	95543
Region 1	TRINITY	95552
Region 1	TRINITY	95563
Region 1	TRINITY	95595
Region 1	TRINITY	96041
Region 1	TRINITY	96046
Region 1	TRINITY	96076

Covered California

Region 1	TRINITY	96091
Region 1	TUOLUMNE	95230
Region 1	TUOLUMNE	95305
Region 1	TUOLUMNE	95311
Region 1	TUOLUMNE	95321
Region 1	TUOLUMNE	95329
Region 1	TUOLUMNE	95335
Region 1	TUOLUMNE	95364
Region 1	TUOLUMNE	95375
Region 1	YUBA	95901
Region 1	YUBA	95914
Region 1	YUBA	95918
Region 1	YUBA	95919
Region 1	YUBA	95922
Region 1	YUBA	95925
Region 1	YUBA	95935
Region 1	YUBA	95941
Region 1	YUBA	95960
Region 1	YUBA	95962
Region 1	YUBA	95966
Region 1	YUBA	95972
Region 1	YUBA	95977
Region 1	YUBA	95981

Zip codes with two (2) plan choices

Region 1	AMADOR	95601
Region 1	AMADOR	95642
Region 1	AMADOR	95654
Region 1	AMADOR	95665
Region 1	AMADOR	95669
Region 1	AMADOR	95675
Region 1	AMADOR	95685
Region 1	AMADOR	95699
Region 1	BUTTE	95916
Region 1	BUTTE	95917
Region 1	BUTTE	95926
Region 1	BUTTE	95927
Region 1	BUTTE	95928

Covered California

Region 1	BUTTE	95929
Region 1	BUTTE	95938
Region 1	BUTTE	95940
Region 1	BUTTE	95948
Region 1	BUTTE	95954
Region 1	BUTTE	95958
Region 1	BUTTE	95965
Region 1	BUTTE	95966
Region 1	BUTTE	95967
Region 1	BUTTE	95968
Region 1	BUTTE	95969
Region 1	BUTTE	95973
Region 1	BUTTE	95974
Region 1	BUTTE	95976
Region 1	BUTTE	95978
Region 1	CALAVERAS	95221
Region 1	CALAVERAS	95222
Region 1	CALAVERAS	95225
Region 1	CALAVERAS	95226
Region 1	CALAVERAS	95246
Region 1	CALAVERAS	95249
Region 1	CALAVERAS	95252
Region 1	COLUSA	95912
Region 1	COLUSA	95932
Region 1	COLUSA	95950
Region 1	COLUSA	95970
Region 1	DEL NORTE	95531
Region 1	DEL NORTE	95532
Region 1	DEL NORTE	95538
Region 1	DEL NORTE	95567
Region 11	FRESNO	93210
Region 11	FRESNO	93234
Region 11	FRESNO	93245
Region 11	FRESNO	93605
Region 11	FRESNO	93608
Region 11	FRESNO	93620
Region 11	FRESNO	93621
Region 11	FRESNO	93622

Covered California

Region 11	FRESNO	93628
Region 11	FRESNO	93634
Region 11	FRESNO	93640
Region 11	FRESNO	93641
Region 11	FRESNO	93642
Region 11	FRESNO	93664
Region 1	GLENN	95913
Region 1	GLENN	95943
Region 1	GLENN	95970
Region 1	GLENN	95988
Region 1	HUMBOLDT	95501
Region 1	HUMBOLDT	95502
Region 1	HUMBOLDT	95503
Region 1	HUMBOLDT	95511
Region 1	HUMBOLDT	95518
Region 1	HUMBOLDT	95519
Region 1	HUMBOLDT	95521
Region 1	HUMBOLDT	95524
Region 1	HUMBOLDT	95525
Region 1	HUMBOLDT	95534
Region 1	HUMBOLDT	95536
Region 1	HUMBOLDT	95537
Region 1	HUMBOLDT	95540
Region 1	HUMBOLDT	95542
Region 1	HUMBOLDT	95545
Region 1	HUMBOLDT	95547
Region 1	HUMBOLDT	95551
Region 1	HUMBOLDT	95553
Region 1	HUMBOLDT	95559
Region 1	HUMBOLDT	95560
Region 1	HUMBOLDT	95562
Region 1	HUMBOLDT	95564
Region 13	IMPERIAL	92004
Region 13	IMPERIAL	92222
Region 13	IMPERIAL	92225
Region 13	IMPERIAL	92227
Region 13	IMPERIAL	92231
Region 13	IMPERIAL	92232
Region 13	IMPERIAL	92233

Covered California

Region 13	IMPERIAL	92243
Region 13	IMPERIAL	92244
Region 13	IMPERIAL	92249
Region 13	IMPERIAL	92250
Region 13	IMPERIAL	92251
Region 13	IMPERIAL	92257
Region 13	IMPERIAL	92259
Region 13	IMPERIAL	92266
Region 13	IMPERIAL	92273
Region 13	IMPERIAL	92281
Region 13	IMPERIAL	92283
Region 13	INYO	92328
Region 13	INYO	92384
Region 13	INYO	92389
Region 13	INYO	93513
Region 13	INYO	93514
Region 13	INYO	93515
Region 13	INYO	93522
Region 13	INYO	93526
Region 13	INYO	93527
Region 13	INYO	93530
Region 13	INYO	93542
Region 13	INYO	93545
Region 13	INYO	93549
Region 14	KERN	93527
Region 14	KERN	93528
Region 14	KERN	93554
Region 14	KERN	93555
Region 14	KERN	93556
Region 14	KERN	93558
Region 11	KINGS	93202
Region 11	KINGS	93204
Region 11	KINGS	93212
Region 11	KINGS	93239
Region 11	KINGS	93245
Region 11	KINGS	93246
Region 11	KINGS	93266
Region 1	LAKE	95422

Covered California

Region 1	LAKE	95424
Region 1	LAKE	95426
Region 1	LAKE	95435
Region 1	LAKE	95443
Region 1	LAKE	95451
Region 1	LAKE	95453
Region 1	LAKE	95457
Region 1	LAKE	95458
Region 1	LAKE	95461
Region 1	LAKE	95464
Region 1	LAKE	95467
Region 1	LAKE	95485
Region 1	LAKE	95493
Region 1	LASSEN	96127
Region 1	LASSEN	96130
Region 1	LASSEN	96137
Region 11	MADERA	93610
Region 11	MADERA	93620
Region 11	MADERA	93622
Region 10	MARIPOSA	95306
Region 10	MARIPOSA	95311
Region 10	MARIPOSA	95318
Region 10	MARIPOSA	95321
Region 10	MARIPOSA	95325
Region 10	MARIPOSA	95329
Region 10	MARIPOSA	95338
Region 10	MARIPOSA	95345
Region 10	MARIPOSA	95389
Region 1	MENDOCINO	95418
Region 1	MENDOCINO	95420
Region 1	MENDOCINO	95437
Region 1	MENDOCINO	95456
Region 1	MENDOCINO	95460
Region 1	MENDOCINO	95470
Region 1	MENDOCINO	95481
Region 1	MENDOCINO	95482
Region 1	MENDOCINO	95490

Covered California

Region 1	MODOC	96101
Region 1	MODOC	96104
Region 1	MODOC	96115
Region 13	MONO	93512
Region 13	MONO	93514
Region 13	MONO	93517
Region 13	MONO	93529
Region 13	MONO	93541
Region 13	MONO	93546
Region 13	MONO	96107
Region 13	MONO	96133
Region 1	NEVADA	95712
Region 1	NEVADA	95724
Region 1	NEVADA	95924
Region 1	NEVADA	95945
Region 1	NEVADA	95946
Region 1	NEVADA	95949
Region 1	NEVADA	95975
Region 1	NEVADA	96111
Region 1	NEVADA	96160
Region 1	NEVADA	96161
Region 1	PLUMAS	95923
Region 1	PLUMAS	95934
Region 1	PLUMAS	95956
Region 1	PLUMAS	95971
Region 1	PLUMAS	95984
Region 1	PLUMAS	96020
Region 1	PLUMAS	96103
Region 1	PLUMAS	96105
Region 1	PLUMAS	96106
Region 1	PLUMAS	96122
Region 1	PLUMAS	96129
Region 1	PLUMAS	96137
Region 17	RIVERSIDE	92225
Region 17	RIVERSIDE	92226
Region 17	RIVERSIDE	92239
Region 9	SAN BENITO	95023

Covered California

Region 9	SAN BENITO	95024
Region 9	SAN BENITO	95045
Region 9	SAN BENITO	95075
Region 17	SAN BERNARDINO	92242
Region 17	SAN BERNARDINO	92267
Region 17	SAN BERNARDINO	92280
Region 17	SAN BERNARDINO	92304
Region 17	SAN BERNARDINO	92323
Region 17	SAN BERNARDINO	92332
Region 17	SAN BERNARDINO	92338
Region 17	SAN BERNARDINO	92363
Region 17	SAN BERNARDINO	92364
Region 17	SAN BERNARDINO	92366
Region 17	SAN BERNARDINO	93516
Region 17	SAN BERNARDINO	93555
Region 17	SAN BERNARDINO	93562
Region 17	SAN BERNARDINO	93592
Region 12	SAN LUIS OBISPO	93252
Region 12	SAN LUIS OBISPO	93401
Region 12	SAN LUIS OBISPO	93402
Region 12	SAN LUIS OBISPO	93403
Region 12	SAN LUIS OBISPO	93405
Region 12	SAN LUIS OBISPO	93406
Region 12	SAN LUIS OBISPO	93407
Region 12	SAN LUIS OBISPO	93408
Region 12	SAN LUIS OBISPO	93409
Region 12	SAN LUIS OBISPO	93410
Region 12	SAN LUIS OBISPO	93412
Region 12	SAN LUIS OBISPO	93420
Region 12	SAN LUIS OBISPO	93421
Region 12	SAN LUIS OBISPO	93422
Region 12	SAN LUIS OBISPO	93423
Region 12	SAN LUIS OBISPO	93424
Region 12	SAN LUIS OBISPO	93426
Region 12	SAN LUIS OBISPO	93428
Region 12	SAN LUIS OBISPO	93430
Region 12	SAN LUIS OBISPO	93432
Region 12	SAN LUIS OBISPO	93433
Region 12	SAN LUIS OBISPO	93435
Region 12	SAN LUIS OBISPO	93442

Covered California

Region 12	SAN LUIS OBISPO	93443
Region 12	SAN LUIS OBISPO	93444
Region 12	SAN LUIS OBISPO	93445
Region 12	SAN LUIS OBISPO	93446
Region 12	SAN LUIS OBISPO	93447
Region 12	SAN LUIS OBISPO	93448
Region 12	SAN LUIS OBISPO	93449
Region 12	SAN LUIS OBISPO	93451
Region 12	SAN LUIS OBISPO	93452
Region 12	SAN LUIS OBISPO	93453
Region 12	SAN LUIS OBISPO	93454
Region 12	SAN LUIS OBISPO	93461
Region 12	SAN LUIS OBISPO	93465
Region 12	SAN LUIS OBISPO	93475
Region 12	SAN LUIS OBISPO	93483

Region 12	SANTA BARBARA	93013
Region 12	SANTA BARBARA	93014
Region 12	SANTA BARBARA	93067
Region 12	SANTA BARBARA	93101
Region 12	SANTA BARBARA	93102
Region 12	SANTA BARBARA	93103
Region 12	SANTA BARBARA	93105
Region 12	SANTA BARBARA	93106
Region 12	SANTA BARBARA	93107
Region 12	SANTA BARBARA	93108
Region 12	SANTA BARBARA	93109
Region 12	SANTA BARBARA	93110
Region 12	SANTA BARBARA	93111
Region 12	SANTA BARBARA	93116
Region 12	SANTA BARBARA	93117
Region 12	SANTA BARBARA	93118
Region 12	SANTA BARBARA	93120
Region 12	SANTA BARBARA	93121
Region 12	SANTA BARBARA	93130
Region 12	SANTA BARBARA	93140
Region 12	SANTA BARBARA	93150
Region 12	SANTA BARBARA	93160
Region 12	SANTA BARBARA	93190
Region 12	SANTA BARBARA	93199
Region 12	SANTA BARBARA	93252
Region 12	SANTA BARBARA	93254

Covered California

Region 12	SANTA BARBARA	93427
Region 12	SANTA BARBARA	93429
Region 12	SANTA BARBARA	93434
Region 12	SANTA BARBARA	93436
Region 12	SANTA BARBARA	93437
Region 12	SANTA BARBARA	93438
Region 12	SANTA BARBARA	93440
Region 12	SANTA BARBARA	93441
Region 12	SANTA BARBARA	93454
Region 12	SANTA BARBARA	93455
Region 12	SANTA BARBARA	93456
Region 12	SANTA BARBARA	93457
Region 12	SANTA BARBARA	93458
Region 12	SANTA BARBARA	93460
Region 12	SANTA BARBARA	93463
Region 12	SANTA BARBARA	93464
Region 9	SANTA CRUZ	95006
Region 9	SANTA CRUZ	95017
Region 9	SANTA CRUZ	95033
Region 1	SHASTA	96001
Region 1	SHASTA	96002
Region 1	SHASTA	96003
Region 1	SHASTA	96007
Region 1	SHASTA	96016
Region 1	SHASTA	96019
Region 1	SHASTA	96025
Region 1	SHASTA	96028
Region 1	SHASTA	96049
Region 1	SHASTA	96073
Region 1	SHASTA	96079
Region 1	SHASTA	96087
Region 1	SHASTA	96089
Region 1	SHASTA	96095
Region 1	SHASTA	96099
Region 1	SIERRA	95910
Region 1	SIERRA	95922
Region 1	SIERRA	95936
Region 1	SIERRA	95944
Region 1	SIERRA	96105

Covered California

Region 1	SIERRA	96125
Region 1	SISKIYOU	96025
Region 1	SISKIYOU	96038
Region 1	SISKIYOU	96067
Region 1	SISKIYOU	96097
Region 1	SUTTER	95626
Region 1	SUTTER	95645
Region 1	SUTTER	95648
Region 1	SUTTER	95659
Region 1	SUTTER	95668
Region 1	SUTTER	95674
Region 1	SUTTER	95676
Region 1	SUTTER	95692
Region 1	SUTTER	95836
Region 1	SUTTER	95837
Region 1	TEHAMA	95973
Region 1	TEHAMA	96035
Region 1	TEHAMA	96055
Region 1	TEHAMA	96078
Region 1	TEHAMA	96080
Region 1	TEHAMA	96090
Region 1	TRINITY	96010
Region 1	TRINITY	96024
Region 1	TRINITY	96048
Region 1	TRINITY	96052
Region 1	TRINITY	96093
Region 1	TUOLUMNE	95309
Region 1	TUOLUMNE	95310
Region 1	TUOLUMNE	95327
Region 1	TUOLUMNE	95346
Region 1	TUOLUMNE	95347
Region 1	TUOLUMNE	95370
Region 1	TUOLUMNE	95372
Region 1	TUOLUMNE	95373
Region 1	TUOLUMNE	95379
Region 1	TUOLUMNE	95383

Covered California

Region 12	VENTURA	93013
Region 12	VENTURA	93023
Region 12	VENTURA	93024
Region 1	YUBA	95692
Region 1	YUBA	95903
Region 1	YUBA	95961



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201**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 IHCA.

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 IHCA, 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) IHCA, 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) IHCA, 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 IHCA, 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 IHCA, 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 IHCA, 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 IHCA (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 _____

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment B1 - Enrollment Projections (Individual)

Issuer Name:

Please provide enrollment projection for each product (HMO/PPO/EPO). Enrollment projections should reflect anticipated enrollment for the Plan Year 2016.

Rating Region	County	2016 Enrollment Projections HMO	2016 Enrollment Projections PPO	2016 Enrollment Projections EPO
Region 1	Alpine			
Region 1	Del Norte			
Region 1	Siskiyou			
Region 1	Modoc			
Region 1	Lassen			
Region 1	Shasta			
Region 1	Trinity			
Region 1	Humboldt			
Region 1	Tehama			
Region 1	Plumas			
Region 1	Nevada			
Region 1	Sierra			
Region 1	Mendocino			
Region 1	Lake			
Region 1	Butte			
Region 1	Glenn			
Region 1	Sutter			
Region 1	Yuba			
Region 1	Colusa			
Region 1	Amador			
Region 1	Calaveras			
Region 1	Tuolumne			
Region 2	Napa			
Region 2	Sonoma			
Region 2	Solano			
Region 2	Marin			
Region 3	Sacramento			
Region 3	Placer			
Region 3	El Dorado			
Region 3	Yolo			
Region 4	San Francisco			
Region 5	Contra Costa			
Region 6	Alameda			
Region 7	Santa Clara			
Region 8	San Mateo			
Region 9	Santa Cruz			
Region 9	Monterey			
Region 9	San Benito			
Region 10	San Joaquin			
Region 10	Stanislaus			
Region 10	Merced			
Region 10	Mariposa			
Region 10	Tulare			
Region 11	Fresno			
Region 11	Kings			
Region 11	Madera			
Region 12	San Luis Obispo			
Region 12	Ventura			
Region 12	Santa Barbara			
Region 13	Mono			
Region 13	Inyo			
Region 13	Imperial			
Region 14	Kern			
Region 15	Los Angeles			
Region 16	Los Angeles			
Region 17	San Bernardino			
Region 17	Riverside			
Region 18	Orange			
Region 19	San Diego			

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment B2 - Enrollment Projections (SHOP)

Issuer Name:

Please provide enrollment projection for each product (HMO/PPO/EPO). Enrollment projections should reflect anticipated enrollment for the Plan Year 2016.

Rating Region	County	2016 Enrollment Projections HMO	2016 Enrollment Projections PPO	2016 Enrollment Projections EPO
Region 1	Alpine			
Region 1	Del Norte			
Region 1	Siskiyou			
Region 1	Modoc			
Region 1	Lassen			
Region 1	Shasta			
Region 1	Trinity			
Region 1	Humboldt			
Region 1	Tehama			
Region 1	Plumas			
Region 1	Nevada			
Region 1	Sierra			
Region 1	Mendocino			
Region 1	Lake			
Region 1	Butte			
Region 1	Glenn			
Region 1	Sutter			
Region 1	Yuba			
Region 1	Colusa			
Region 1	Amador			
Region 1	Calaveras			
Region 1	Tuolumne			
Region 2	Napa			
Region 2	Sonoma			
Region 2	Solano			
Region 2	Marin			
Region 3	Sacramento			
Region 3	Placer			
Region 3	El Dorado			
Region 3	Yolo			
Region 4	San Francisco			
Region 5	Contra Costa			
Region 6	Alameda			
Region 7	Santa Clara			
Region 8	San Mateo			
Region 9	Santa Cruz			
Region 9	Monterey			
Region 9	San Benito			
Region 10	San Joaquin			
Region 10	Stanislaus			
Region 10	Merced			
Region 10	Mariposa			
Region 10	Tulare			
Region 11	Fresno			
Region 11	Kings			
Region 11	Madera			
Region 12	San Luis Obispo			
Region 12	Ventura			
Region 12	Santa Barbara			
Region 13	Mono			
Region 13	Inyo			
Region 13	Imperial			
Region 14	Kern			
Region 15	Los Angeles			
Region 16	Los Angeles			
Region 17	San Bernardino			
Region 17	Riverside			
Region 18	Orange			
Region 19	San Diego			

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment C1 - Plan Type by Rating Region (Individual)

Selecting a box below means Issuer will submit a QHP bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan in order to submit an HSA Plan.

INDIVIDUAL								
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 1	Alpine							
Region 1	Del Norte							
Region 1	Siskiyou							
Region 1	Modoc							
Region 1	Lassen							
Region 1	Shasta							
Region 1	Trinity							
Region 1	Humboldt							
Region 1	Tehama							
Region 1	Plumas							
Region 1	Nevada							
Region 1	Sierra							
Region 1	Mendocino							
Region 1	Lake							
Region 1	Butte							
Region 1	Glenn							
Region 1	Sutter							
Region 1	Yuba							
Region 1	Colusa							
Region 1	Amador							
Region 1	Calaveras							
Region 1	Tuolumne							
Region 2	Napa							
Region 2	Sonoma							
Region 2	Solano							
Region 2	Marin							
Region 3	Sacramento							

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 3	Placer							
Region 3	El Dorado							
Region 3	Yolo							
Region 4	San Francisco							
Region 5	Contra Costa							
Region 6	Alameda							
Region 7	Santa Clara							
Region 8	San Mateo							
Region 9	Santa Cruz							
Region 9	Monterey							
Region 9	San Benito							
Region 10	San Joaquin							
Region 10	Stanislaus							
Region 10	Merced							
Region 10	Mariposa							
Region 10	Tulare							
Region 11	Fresno							
Region 11	Kings							
Region 11	Madera							
Region 12	San Luis Obispo							
Region 12	Ventura							
Region 12	Santa Barbara							
Region 13	Mono							
Region 13	Inyo							
Region 13	Imperial							
Region 14	Kern							
Region 15	Los Angeles							
Region 16	Los Angeles							
Region 17	San Bernardino							
Region 17	Riverside							
Region 18	Orange							
Region 19	San Diego							

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment C2 - Plan Type by Rating Region (SHOP)

Selecting a box below means Issuer will submit a QHP bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan in order to submit an HSA Plan.

SHOP									
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 1	Alpine								
Region 1	Del Norte								
Region 1	Siskiyou								
Region 1	Modoc								
Region 1	Lassen								
Region 1	Shasta								
Region 1	Trinity								
Region 1	Humboldt								
Region 1	Tehama								
Region 1	Plumas								
Region 1	Nevada								
Region 1	Sierra								
Region 1	Mendocino								
Region 1	Lake								
Region 1	Butte								
Region 1	Glenn								
Region 1	Sutter								
Region 1	Yuba								
Region 1	Colusa								
Region 1	Amador								
Region 1	Calaveras								
Region 1	Tuolumne								
Region 2	Napa								
Region 2	Sonoma								
Region 2	Solano								
Region 2	Marin								
Region 3	Sacramento								

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 3	Placer								
Region 3	El Dorado								
Region 3	Yolo								
Region 4	San Francisco								
Region 5	Contra Costa								
Region 6	Alameda								
Region 7	Santa Clara								
Region 8	San Mateo								
Region 9	Santa Cruz								
Region 9	Monterey								
Region 9	San Benito								
Region 10	San Joaquin								
Region 10	Stanislaus								
Region 10	Merced								
Region 10	Mariposa								
Region 10	Tulare								
Region 11	Fresno								
Region 11	Kings								
Region 11	Madera								
Region 12	San Luis Obispo								
Region 12	Ventura								
Region 12	Santa Barbara								
Region 13	Mono								
Region 13	Inyo								
Region 13	Imperial								
Region 14	Kern								
Region 15	Los Angeles								
Region 16	Los Angeles								
Region 17	San Bernardino								
Region 17	Riverside								
Region 18	Orange								
Region 19	San Diego								

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment D1 - Provider Data

Please refer to the lookup table in the Excel Attachment for specific input values

PCP Tab

Row #	Last Name	Middle Name	NPI	CA License	Participating Product/Network	Tier	Provider Language	Practice Address	Practice Address 2	Practice City	Practice County	Practice State	Practice Zip Code	Accepting New Patients	Specialty
1															
2															
3															
...															

Specialist Tab

Row #	Last Name	Middle Name	NPI	CA License	Participating Product/Network	Tier	Provider Language	Practice Address	Practice Address 2	Practice City	Practice County	Practice State	Practice Zip Code	Accepting New Patients	Specialty
1															
2															
3															
...															

Hospital Tab

Row #	Hospital Name	Alternate Name	Address	Address 2	City	County	State	Zip Code	NPI	CA Facility ID	Hospital System	Participating Product/Network	Tier
1													
2													
3													
...													

Medical Groups/IPAs Tab

Row #	Medical Group/IPAs	Alternative Name	Address	Address 2	City	County	State	Zip Code	DMHC ID	Federal Tax ID	Participating Product/Network	Tier	Capitated/Non-Capitated
1													
2													
3													
...													

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment D2 - ECP Providers

This is an example of the ECP Pick List that will be made available from the link provided in the application. Applicants are requested to indicate which of the entities on the list are participating in their network by choosing "Yes" or "No" in the appropriate product column.

In- Network PPD	In- Network EPD	In- Network HMO	Entity Name	Entity Sub-Division Name	Address 1	Address 2	City	County	Zip	Rating Region	340B Entity Type	CDPH Licensed Clinic Type
			A Woman'S Friend Preg Resource Ctr & Med Clinic	A Woman'S Friend Preg Resource Ctr & Med Clinic	616 E St		Marysville	YUBA	95901	1		Community Clinic
			Ampla Health	Ampla Health Arbuckle Medical & Dental	89 Putnam Way		Arbuckle	Colusa	95912	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Chico Dental	236 W East Ave		Chico	Butte	95926	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Chico Medical & Pediatrics	680 Cohasset Rd		Chico	Butte	95926	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Colusa Medical & Dental	555 Fremont St		Colusa	Colusa	95932	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Gridley Medical	520 Kentucky St		Gridley	Butte	95948	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Hamilton City Medical	278 Main St		Hamilton City	Glenn	95951	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Los Molinos Medical	7981 Hwy 99E		Los Molinos	TEHAMA	96055	1		Community Clinic
			Ampla Health	Ampla Health Lindhurst Medical & Dental	4941 Olivehurst Ave		Olivehurst	Yuba	95961	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Orland Medical & Dental	1211 Cortina Dr		Orland	Glenn	95963	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Oroville Medical & Dental	2800 Lincoln St		Oroville	Butte	95966	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Corporate Office	935 Market St	Ste A	Yuba City	Sutter	95991	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Richland Medical	334 Samuel Dr		Yuba City	Sutter	95991	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Yuba City Medical	1000 Sutter St		Yuba City	Sutter	95991	1	Consolidated Health Center Program*	Community Clinic
			Ampla Health	Ampla Health Yuba City Pediatrics	931 Market St		Yuba City	Sutter	95991	1	Consolidated Health Center Program*	Community Clinic
			Anderson Valley Health Center	Anderson Valley Health Center	13500 Airport Rd		Boonville	Mendocino	95415	1	Consolidated Health Center Program*	Community Clinic
			Butte County Dept Of Public Health	Administrative Office	202 Mira Loma Dr		Oroville	Butte	95965	1	Family Planning	
			Butte County Public Health	Oleander Clinic	695 Oleander Ave		Chico	Butte	95926	1	Family Planning	
			Butte County Public Health	Table Mountain Clinic	78 Table Mountain Blvd		Oroville	Butte	95965	1	Family Planning	
			Butte Department Of Public	Butte Department Of Public	202 Mira Loma Dr		Oroville	Butte	95965	1	STD	
			Chapa-De Indian Health Program - Corporate Office	Chapa-De Indian Health Program - Grass Valley	1061 E Main St		Grass Valley	Nevada	95945	1		
			Chapa-De Indian Health Program Inc	Grass Valley Clinic	1350 E Main St		Grass Valley	Nevada	95945	1	Tribal Contract/Compact with IHS	Community Clinic
			Colusa Indian Health Clinic	Colusa Indian Health Clinic	3710 Highway 45	Suite A	Colusa	Colusa	95932	1	Tribal Contract/Compact with IHS	
			Consolidated Tribal Health Project	Consolidated Tribal Health Project	6991 N State St		Redwood Valley	Mendocino	95470	1	Tribal Contract/Compact with IHS	Community Clinic
			County Of Amador	Amador County Public Health	10877 Conductor Blvd	Suite 400	Sutter Creek	Amador	95685	1	STD	

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment E1 - Delivery System Reform (Individual)

Indicate the geography and contracted providers engaged in delivery system initiatives, and expected availability for the Individual Exchange enrollees. For the columns indicating the number of members and physicians included, report data as of January 1, 2015; if current data are not available, report data as of September 30, 2014.

Rating Region	Type of Initiative *(see definitions below)	Geographic Availability	Product Availability	List partner organizations (medical groups and hospitals)	Number of members included in the program	Number of primary care physicians included in the program	Number of specialists included in the program
	<i>Multi, Choice</i> Accountable Care Organization Primary Care Medical Home	<i>Single, Pull-down list</i> Full Region Partial Region Not Offered	<i>Single, Pull-down list</i> Available to the Exchange in 2015 Not Available to the Exchange May be available to the Exchange after 2015	<i>Detail box 500 words</i>	<i>Numeric</i>	<i>Numeric</i>	<i>Numeric</i>
Region 1							
Region 2							
Region 3							
Region 4							
Region 5							
Region 6							
Region 7							
Region 8							
Region 9							
Region 10							
Region 11							
Region 12							
Region 13							
Region 14							
Region 15							
Region 16							
Region 17							
Region 18							
Region 19							

*Accountable Care Organizations means that there is both upside and downside risk for participants with gainsharing available to purchasers or consumers

*Primary Care Medical Home means a targeted effort to support practice transformation and steerage of members to PCMH-designated providers

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment E2 - Delivery System Reform (Individual)

Indicate the geography and contracted providers engaged in delivery system initiatives, and expected availability for the SHOP Exchange enrollees. For the columns indicating the number of members and physicians included, report data as of January 1, 2015; if current data are not available, report data as of September 30, 2014.

Rating Region	Type of Initiative *(see definitions below)	Geographic Availability	Product Availability	List partner organizations (medical groups and hospitals)	Number of members included in the program	Number of primary care physicians included in the program	Number of specialists included in the program
	<i>Multi Choice</i> Accountable Care Organization Primary Care Medical Home	<i>Single, Pull-down list</i> Full Region Partial Region Not Offered	<i>Single, Pull-down list</i> Available to the Exchange in 2015 Not Available to the Exchange May be available to the Exchange after 2015	<i>Detail box 500 words</i>	<i>Numeric</i>	<i>Numeric</i>	<i>Numeric</i>
Region 1							
Region 2							
Region 3							
Region 4							
Region 5							
Region 6							
Region 7							
Region 8							
Region 9							
Region 10							
Region 11							
Region 12							
Region 13							
Region 14							
Region 15							
Region 16							
Region 17							
Region 18							
Region 19							

*Accountable Care Organizations means that there is both upside and downside risk for participants with gainsharing available to purchasers or consumers

*Primary Care Medical Home means a targeted effort to support practice transformation and steering of members to PCMH-designated providers

California Health Benefit Exchange
QHP New Entrant Certification Application for Plan Year 2016
Attachment G - SHOP Alternate Benefit Design

Input the cost sharing amounts that describe the enrollee's out-of-pocket costs for each benefit category. List any exclusions in the column on the right.

Applicant is offering a Standard

Plan across all metal levels.

Yes

No

		Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Provide additional detail including any exclusions
		Silver Alternate Plan	Silver Alternate Plan	Platinum Alternate Plan (Optional)	Platinum Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Bronze Alternate Plan (Optional)		
		Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers		
12/28/2012											
Estimated Annual Value		%	%	%	%	%	%	%	%		
Overall deductible		\$	\$	\$	\$	\$	\$	\$	\$		
Other deductibles for specific services		\$	\$	\$	\$	\$	\$	\$	\$		
Facility-related Services		\$	\$	\$	\$	\$	\$	\$	\$		
Brand Drugs		\$	\$	\$	\$	\$	\$	\$	\$		
Dental		\$	\$	\$	\$	\$	\$	\$	\$		
Out-of-pocket limit on expenses		\$	\$	\$	\$	\$	\$	\$	\$		
Service Type	Professional/ Hospital	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Provide additional detail including any exclusions
Visit to a health care provider's office or clinic											
Primary care visit to treat an injury or illness (deductible waived for first visit except Non-Par Providers or HSA plans-- see footnote)		Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	Drop down - Value entered as ___% or ___\$	text box. 100 words - replicate below
Specialist visit		Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	
Other practitioner office visit											
Preventive care/ screening/ immunization											
Tests											
Diagnostic test (x-ray, blood work)											
Imaging (CT/PET scans, MRIs)											
Drugs to treat illness or condition											
Generic drugs											
Preferred brand drugs											
Non-preferred brand drugs											
Specialty drugs											
Outpatient surgery											
Facility fee (e.g., ambulatory surgery center)											

		Silver Alternate Plan	Silver Alternate Plan	Platinum Alternate Plan (Optional)	Platinum Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Provide additional detail including any exclusions
		Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	
Physician/surgeon fees										
to determine if										
Emergency room services										
Emergency medical transportation										
Urgent care										
to determine if										
Facility fee (e.g. hospital room)										
Physician/surgeon fee										
to determine if										
Mental health, behavioral health, or substance abuse										
to determine if										
Mental/Behavioral health outpatient services										
Mental/Behavioral health inpatient services										
Substance use disorder outpatient services										
Substance use disorder inpatient services										
to determine if										
Pregnancy										
Prenatal and postnatal care										
Delivery and all inpatient services	Professional									
Delivery and all inpatient services	Hospital									
to determine if										
Special health needs										
Home health care										
Rehabilitation services										
Habilitation services										
Skilled nursing care										
Durable medical equipment										
Hospice service										
to determine if										
Child needs or eye care										
Eye exam (deductible waived)										
Glasses										
Dental check-up - Preventive and Diagnostic Services (deductible waived)										
Dental Basic Services										
Dental Restorative and Orthodontia Services										

HEDIS[®] 2014
TECHNICAL SPECIFICATIONS
FOR HEALTH PLANS

Volume 2

INCOA

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

SUMMARY OF CHANGES TO HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.

Description

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Definition

Treatment days (covered days) The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval).

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 18 years and older as of December 31 of the measurement year.

Continuous enrollment Discharge date through 180 days after discharge.

Allowable gap No more than one gap in enrollment of up to 45 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

Anchor date Discharge date.

Benefit Medical and pharmacy.

Event/diagnosis Discharged alive from an acute inpatient setting with an AMI (AMI Value Set) from July 1 of the year prior to the measurement year through June 30 of the measurement year. Use only facility claims to identify AMI. Do not use diagnoses from professional claims to identify AMI.

If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, organizations should only include the first discharge.

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another acute inpatient facility for any diagnosis. Count the discharge from the subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the member was transferred must occur on or before June 30 of the measurement year.

Transfers to nonacute facilities. Exclude from the denominator, hospitalizations in which the member was transferred directly to a nonacute care facility for any diagnosis.

Readmissions. If the member was readmitted to an acute or nonacute care facility for any diagnosis, include the member in the denominator and use the discharge date from the original hospitalization.

Administrative Specification

Denominator The eligible population.

Numerator A 180-day course of treatment with beta-blockers (Table PBH-B).

Identify all members in the denominator population whose dispensed days supply is ≥ 135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

To determine continuity of treatment during the 180-day period, identify all prescriptions filled within 180 days of the discharge date, and add the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days).

To account for members who are on beta-blockers prior to admission, the organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	<ul style="list-style-type: none"> • Carteolol • Carvedilol • Labetalol 	<ul style="list-style-type: none"> • Nadolol • Penbutolol • Pindolol 	<ul style="list-style-type: none"> • Propranolol • Timolol • Sotalol
Cardioselective beta-blockers	<ul style="list-style-type: none"> • Acebutolol • Atenolol 	<ul style="list-style-type: none"> • Betaxolol • Bisoprolol 	<ul style="list-style-type: none"> • Metoprolol • Nebivolol
Antihypertensive combinations	<ul style="list-style-type: none"> • Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide 	<ul style="list-style-type: none"> • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol 	

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.

Exclusion (optional)

Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through the end of the continuous enrollment period meet criteria:

- Asthma (Asthma Value Set).
- COPD (COPD Value Set).
- Obstructive chronic bronchitis (Obstructive Chronic Bronchitis Value Set).
- Chronic respiratory conditions due to fumes and vapors (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set).
- Hypotension, heart block >1 degree or sinus bradycardia (Beta-Blocker Contraindications Value Set).
- A medication dispensing event indicative of a history of asthma (Table PBH-D).
- Intolerance or allergy to beta-blocker therapy.

- *Prior MI.* Documentation of prior MI. Look as far back as possible in the member's history through December 31 of the measurement year.
- *ESRD.* Documentation of stage 5 chronic kidney disease, ESRD or dialysis. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Chronic kidney disease (stage 4).* Documentation of stage 4 chronic kidney disease. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Dementia.* Documentation of dementia. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Blindness.* Documentation of blindness in one or both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Amputation (lower extremity).* Documentation of lower extremity amputation. Look as far back as possible in the member's history through December 31 of the measurement year.

Note: For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but should exclude these members if they are discovered during medical record review.

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Organizations may count notation of the following in the medical record:

- A1c.
- Hemoglobin A1c.
- HgbA1c.
- HbA1c.
- Glycohemoglobin A1c.

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <8% The most recent HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is $\geq 8.0\%$ or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <7% for a Selected Population The most recent HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.

Note: This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions).

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is $\geq 7.0\%$ or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Eye Exam An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional meets criteria).

LDL-C Screening An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result or finding.

The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

LDL-C Control <100 mg/dL The *most recent* LDL-C level performed during the measurement year is <100 mg/dL, as documented through automated laboratory data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation in the medical record must include, at a minimum, a note indicating the date when the LDL-C test was performed and the result. The member is numerator compliant if the most recent LDL-C level during the measurement year is <100 mg/dL. The member is not numerator compliant if the result for the most recent LDL-C test is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year.

A documented range or threshold that indicates the most recent result is less than 100 mg/dL meets criteria.

The organization may calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

$$(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5)$$

If lipoprotein (a) is measured, use the following calculation.

$$(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5) - 0.3 [\text{lipoprotein (a)}]$$

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

The Friedewald equation may not be used if a direct or calculated result is present in the medical record for the most recent LDL-C test.

Medical Attention for Nephropathy A nephropathy screening test during the measurement year *or* evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: A process flow diagram is included at the end of this specification to help implement this specification.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.



Technical Specifications for PQA Approved Measures

JULY 2013

6312 Old Keene Mill Court □ Springfield, VA 22039
Phone: 703-690-1987 □ www.PQAalliance.org □ Fax: 703-690-1756

PQA Measures

Adherence and Persistence

The Adherence and Persistence measures examine patients' refills of medications for particular therapeutic drug classes. Two methods were selected to give complementary perspectives on adherence and persistence: the proportion of days covered and the gap in therapy. Because Proportion of Days Covered is the preferred method to measure adherence, PQA provides updates for only this methodology.

Proportion of Days Covered (PDC)

Proportion of Days Covered (PDC) measures assess the percentage of patients covered by prescription claims for the same drug or for another drug in the same therapeutic class, within the measurement year. The PDC threshold is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit; clinical evidence provides support for a standard PDC threshold of 80%.

- Beta-Blockers (BB)
- Renin Angiotensin System (RAS) Antagonists (ACEI/ARB/Direct Renin Inhibitors)
- Calcium-Channel Blockers (CCB)
- Diabetes Medications (biguanides, DPP-IV inhibitors, sulfonylureas, thiazolidinediones, diabetes all-class)
- Cholesterol Medications (HMG-CoA inhibitors – Statins)
- Antiretroviral Medications (requires 90% threshold for at least 2 antiretroviral medications)
- Non-Warfarin Oral Anticoagulants

Appropriate Medication Use

The Diabetes Medication measures assess two areas of diabetes medication use: the appropriate dosing of diabetes medication and the treatment regimen for patients taking diabetes medications. The *Diabetes Medication Dosing* measure assesses the percentage of patients who were dispensed a dose higher than the daily recommended dose for diabetes medications. The *Diabetes: Appropriate Treatment of Hypertension* measure assesses the percentage of patients who were dispensed a medication for diabetes and a medication for hypertension and who were dispensed an ACEI or ARB or Direct Renin Inhibitor medication.

- Diabetes Medication Dosing (DOS)
- Diabetes: Appropriate Treatment of Hypertension (APP)

The respiratory medication measures assess two areas of respiratory medication use. *Suboptimal Asthma Control* assesses the percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler over any three-month period. *Absence of Controller Therapy* assesses the percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler over any three-month period and who did not receive the appropriate controller therapy.

- Absence of Controller Therapy (ACT)
- Suboptimal Asthma Control (SAC)

A cardiovascular medication measure addresses the appropriate management of cholesterol in patients with coronary artery disease (CAD). This measure requires data to confirm a diagnosis of CAD as well as drug utilization data to determine whether the CAD patients received a HMG-CoA reductase inhibitor (i.e. statin) medication.

- Cholesterol Management in Coronary Artery Disease

Measure Specifications

Adherence/Persistence Measures

- Proportion of Days Covered (PDC)

Diabetes Medication Measures

- Diabetes Medication Dosing (DOS)
- Diabetes: Appropriate Treatment of Hypertension (APP)

Respiratory Medication Measures

- Absence of Controller Therapy (ACT)
- Suboptimal Asthma Control (SAC)

Medication Safety Measure

- Use of High-Risk Medications in the Elderly (HRM)
- Drug-drug Interactions (DDI)
- Antipsychotic Use in Persons with Dementia (APD)
- Antipsychotic Use in Children under 5 Years

Cardiovascular Measure

- Cholesterol Management in Patients with Coronary Artery Disease (CAD)

MTM Measure

- Completion Rate for Comprehensive Medication Review (CMR)

Medication Therapy for Persons with Asthma

Description

The percentage of patients with asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler over a 90-day period and who did not receive controller therapy during the same 90-day period. Two rates are reported.

- **Suboptimal Control.** The percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.
- **Absence of Controller Therapy.** The percentage of patients with asthma during the measurement period who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.

Definitions

Consecutive Fill The dispensing of two asthma medications within four months of one another.

Eligible Population

Ages 5 – 50 years of age as of the last day of the measurement year.

Continuous enrollment

...using enrollment data

Subjects should be continuously enrolled during the measurement period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).

Proxy for enrollment when using pharmacy-only data

Two or more prescriptions for any medication, with 150 days between the first fill and the last fill, over a 12 month period.

Measurement Period

The patient's measurement period begins on the date of the first fill of the target medication (i.e., index date) and extends through the last day of the enrollment period or until death or disenrollment. The index date should occur at least 91 days before the end of the enrollment period.

Benefit

Pharmacy.

Stratification

Commercial, Medicaid, Medicare (report each product line separately).

Event/Diagnosis

Step 1 Identify patients with consecutive fills of asthma medications (*Refer to Table SAC-A*) during the measurement year.

Step 2 Exclude patients identified in step 1 who meet any of the following criteria:

- filled at least one prescription for a COPD medication (*Refer to Table SAC-B*) during the measurement year.

- filled at least one prescription for pulmozyme (Refer to Table SAC-C) during the measurement year.
- filled at least one prescription for a nasal steroid medication (Refer to Table SAC-D) during the measurement year.

Table SAC-A: Asthma Medications

Short-Acting Inhaled Beta Agonists			
• albuterol MDI/HFA		• pirbuterol	• levalbuterol HFA
Long-Acting Beta Agonists			
• salmeterol	• formoterol	• fluticasone & salmeterol	• budesonide & formoterol • mometasone & formoterol
Inhaled Corticosteroids			
• beclomethasone	• fluticasone	• fluticasone & salmeterol	• triamcinolone
• budesonide		• mometasone	• budesonide & formoterol
• ciclesonide			• mometasone & formoterol
Leukotriene Inhibitors			
• zafirlukast	• montelukast	• zileuton	
Xanthines			
• long acting theophylline			

Note: Active ingredients for inhaled products are limited to MDI/HFA inhaled formulations only (excludes nebulizer solution); excludes omalizumab (limited use - omalizumab is only indicated for adults and adolescents 12 years of age and older with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids).

Table SAC-B: COPD Medications

COPD Medications		
• tiotropium	• ipratropium/albuterol	• ipratropium
• indacaterol	• roflumilast	• acridinium bromide

Note: Active ingredients are limited to oral and MDI/HFA inhaled formulations only (excludes nebulizer solution).

Table SAC-C: Cystic Fibrosis Agents

Cystic Fibrosis Agents
• dornase alfa (Pulmozyme®) ivacaftor
• tobramycin inh. capsules (TOBI Podhaler®)

Note: Active ingredients are limited to inhaled and oral formulations only.

Table SAC-D Nasal Steroid Medications

Nasal Steroids		
• beclomethasone	• flunisolide	• mometasone
• budesonide	• fluticasone	• triamcinolone
		• ciclesonide

Note: Active ingredients are limited to intranasal formulations only.

Administrative Specification

Denominator The eligible population.

Numerator

Suboptimal Asthma Control From the date of each prescription fill, count the total number of canisters of short acting Beta2 Agonist Inhalers (Refer to Table SAC-E) dispensed within 90 days of that initial fill. If the patient receives more than 3 canisters in at least one 90 day period, then the patient is compliant for the numerator.

Note: This is a count of canisters dispensed, not prescriptions filled. If a patient received 2 canisters at one fill, it counts as 2 canisters.

Table SAC-E: Short-Acting Beta2 Agonist Inhalers

Short-Acting Inhaled Beta-Agonist		
• albuterol MDI/HFA	• pirbuterol	• levalbuterol HFA
Note: Active ingredients are limited to MDI/HFA inhaled formulations only (excludes nebulizer solution).		

Absence of Controller

Step 1 Count the total number of canisters of short acting Beta2 Agonist Inhalers (Refer to Table SAC-E) dispensed within 90 days of that initial fill. If the patient receives more than 3 canisters in at least one 90 day period, then the patient is compliant for the numerator

Step 2 Count the patients who were *not* dispensed a controller therapy (Refer to Table ACT-A) medication during the same 90-day period(s).

Table ACT-A: Controller Therapy

Inhaled Corticosteroids			
• beclomethasone	• fluticasone	• fluticasone & salmeterol	• triamcinolone
• budesonide		• mometasone	• ciclesonide
		• mometasone & formoterol	• budesonide & formoterol
Long-Acting Beta-Agonists			
• salmeterol	• formoterol	• fluticasone & salmeterol	• budesonide & formoterol
			• mometasone & formoterol
Leukotriene Inhibitors			
• zafirlukast	• montelukast	• zileuton	
Xanthines			
• long acting theophylline			

Note: Active ingredients for inhaled products are limited to MDI/HFA inhaled formulations only (excludes nebulizer solution); excludes omalizumab (limited use - omalizumab is only indicated for adults and adolescents 12 years of age and older with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids).

Terms	Definition
Attribution	Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purpose 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, PCMH, or other delivery models in which patients are attributed to a provider with any payment reform contract. For the purposes of the Scorecard, attribution is for Commercial (self-funded and fully-insured) lives only. It does not include Medicare Advantage or Medicaid beneficiaries.
Bonus payments based on measures of quality and/or efficiency	Payments made that reward providers for performance in quality and/or efficiency relative to predetermined benchmarks, such as meeting pre-established performance targets, demonstrating improved performance, or performing better than peers. Bonus payments can include programs that pay providers lump sum payments for achieving performance targets (quality and/or efficiency metrics). Bonus payments can also include payments tied to a provider's annual percentage increase in FFS payments based on their achievement of performance metrics. Bonus payments do NOT include payments made under shared savings arrangements that give providers an increased share of the savings based on performance.
Bundled payment	Also known as "episode-based payment," bundled payment means a single payment to providers or healthcare facilities (or jointly to both) for <u>all</u> services to treat a given condition or to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications. An example is payment to obstetricians for the ongoing management of pregnancy, <u>delivery and postpartum care</u> .
Condition-specific capitation	A fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.
Dollars paid	Claims and incentives that were paid to providers (including individual physicians, IPAs, medical groups, and/or inpatient and outpatient facilities) for services delivered to health plan participants in the past year, during the 12 month reporting period, regardless of the time period when the claim or incentive payment was/is due. (i.e., regardless of when the claim was received or when the service was rendered or period of when performance was measured). For example, incentive payments that were paid in calendar year 2013 for performance in calendar year 2012 should be reported. Claims for 2013 services that are in adjudication and not yet paid during the reporting period should not be included in this response.
Episode-based payment	See definition for "Bundled Payment".
FFS-based payment	Payment model where providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. For the purposes of the CPR Scorecard, DRGs, case rates, and <u>per diem hospital payments are considered FFS-based payment.</u>
Full capitation with quality	A fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance (quality, safety, and efficiency) and patient risk. Includes quality of care components with pay-for-performance. Full capitation on top of which a quality bonus is paid (e.g. P4P) is considered <u>full capitation with quality.</u>
Full capitation without quality	A fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year. Payments may or may not be adjusted for patient risk and there are no payment adjustments based on <u>measured performance, such as quality, safety, and efficiency.</u>
Hospital-physician gainsharing	Arrangement in which hospitals and physicians share the cost savings achieved through collaborative efforts resulting in <u>improved quality and/or efficiency.</u>
Maternity care services	Includes any or all of the following services: prenatal care (such as office visits and screening tests), labor and delivery services (including hospitalization), care resulting from complications related to a pregnancy, and postpartum/postnatal care (including NICU). Fertility services are not included in the definition of maternity care services.
Member support tools	Tools (e.g. web-based) that provide transparency including but not limited to quality metrics, quality information about physicians or hospitals, benefit design information, out-of-pocket costs associated with expected treatment or services, average price of service, and account balance information (e.g. deductibles).
Non-FFS-based payment	Payment model where providers receive payment not based on the FFS payment system or not tied to a FFS fee schedule (e.g. <u>bundled payment, full capitation.</u>)
Non-visit function	Includes but is not limited to payment for outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists.
Partial capitation	A fixed dollar payment to providers for specific services (e.g. payments for high-cost items such as specific drugs or medical devices, like prosthetics) that patients may receive in a given time period, such as a month or year. <u>Non-specified services remain reimbursed under fee-for-service.</u>
Past year (in definition for dollars paid)	Means calendar year 2013 or the most current 12 month period for which Plan can report payment information. This is the reporting period for which the Plan should report all of its data. See also definition of "Reporting Period."
Pay-for-performance	Provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment models. The financial incentive payment that is given for achieving certain performance levels is sometimes also referred to as a bonus payment. See "Bonus Payment" definition.

Payment reform	Refers to a range of health care payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.
Plan members	Health plan's enrollees or plan participants.
Primary Care Physicians	A primary care physician is a generalist physician who provides care to patients at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine. For the purposes of this data collection, PCPs are not specialists. See definition of "specialists."
Primary Care Services	Refers to the services a patient receives at first contact with the health care system, usually involving coordination of care and continuity across providers and settings over time. Primary care services includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care services are performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. There are providers of health care other than physicians who render some primary care services; such as nurse practitioners (NPs), physician assistants (PAs) and some other health care providers. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services and involves effective communication with patients and encourages the role of the patient as a partner in health care. [NOTE dollars paid WLP, NP, PAs can be captured in question asking about primary care services]
Program Sponsor	Entity that is the primary owner or administrator of the payment reform program.
Providers	Physicians, non-physician clinicians (e.g. nurse practitioner), IPAs, medical groups, and inpatient or outpatient facilities, including ancillary providers.
Quality/Quality Components	A payment reform program that incentivizes, requires, or rewards some component of the provision of safe, timely, patient centered, effective, efficient, and/or equitable health care.
Reference pricing	Approach to pricing that establishes a health-plan determined covered amount (price) for a procedure, service or bundle of services, and generally requires that health plan participants pay any allowed charges beyond this amount. Common reference pricing programs are primarily effected through benefit design changes and are for commodity services such as labs, imaging, and colonoscopies and other services where quality is thought not to vary. For the purposes of the CPR Scorecard, reference pricing does not apply to prescription drugs.
Reporting Period	Reporting period refers to the time period for which the Plan should report all of its data. Unless otherwise specified, reporting period refers to calendar year (CY) 2013. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of calendar year 2013, the Plan may elect to report for the time period on the most recent 12 months with sufficient information and note the time period in the "Other Information section at the end of Provider Module" in eValue8 2014. -If this election is made, ALL answers on payment dollar questions for CY 2013 should reflect the adjusted reporting period.
Shared-risk	Refers to arrangements in which providers accept some financial liability for <u>not</u> meeting specified financial targets. It may also include arrangements in which providers accept some financial liability for not meeting specified quality targets . Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of this data collection, shared-risk programs that include shared-savings as well as downside risk should only be included in the shared-risk category. Shared-risk programs are based on a FFS payment system and for the purposes of the CPR Scorecard, shared risk does not include bundled payment, full capitation, or partial or condition-specific capitation.
Shared savings	Provides an upside-only financial incentive for providers or provider entities to reduce <u>unnecessary</u> health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared-savings programs can be based on a FFS payment system. Shared Savings can be applied to some or all of the services that are expected to be used by a patient population and will vary based on <u>provider performance</u> .
Specialists	Specialist physicians have a recognized expertise in a specific area of medicine. They have undergone formal residency and/or fellowship training programs and have passed the specialty board examination in that field. Examples include oncologists, ENTs, cardiologists, OB-GYNs, etc. For the purposes of this data collection, specialists are not PCPs. See definition of "primary care physicians."
Unnecessary elective medical intervention during labor and delivery in the past year	Unnecessary intervention includes non-medically indicated (elective) labor induction and cesarean deliveries. Contracts that provide incentives for adhering to clinical guidelines related to unnecessary elective medical intervention during labor and delivery may include provisions that require hospitals to implement a "hard stop" policy, include a "do not pay" directive, or require prior authorization for elective labor induction and cesarean deliveries prior to 39 weeks.
Value-Pricing	Refer to definition of "reference pricing." Value pricing builds upon reference pricing by focusing on <u>services where quality is thought to vary</u> and requiring providers to meet certain quality thresholds to participate.

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