Attachment 7 – Quality, Network Management, Delivery System Standards and Improvement Strategy

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. Covered California and Contractor recognize that promoting better quality and value will be contingent upon supporting Providers and strategic, collaborative efforts to align with other major purchasers and payors to support delivery system reform. Qualified Health Plan (QHP) Issuers are integral to Covered California achieving its mission:

> *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.*

By entering into this Agreement with Covered California, Contractor agrees to work with Covered California to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of Covered California but Contractor's entire California membership. All QHP Issuers have the opportunity to take a leading role in helping Covered California support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and Covered California can promote improvements in the entire care delivery system. Covered California will seek to promote care that reduces excessive costs, minimizes unpredictable quality and reduces inefficiencies of the current system. In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable and expand beyond local markets or specific groups of individuals. Covered California expects its QHP Issuers to support their Providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and all individuals covered by the QHP Issuers.

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

Covered California and Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term

of this agreement. Success will depend on establishing targets based on current performance, national benchmarks and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

ARTICLE 1
IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

1.01 Coordination and Cooperation

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

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

   (a) Enrollees and other consumers;

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

   (c) Contractors in terms of the burden of reporting and participating in quality or delivery system efforts.

2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and Provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

1) Include quality, which may include clinical quality, patient safety and patient experience and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products

2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and Provider or facility selection. Information submitted for the application for certification in 2019 may be made publicly

available by Covered California.

3) Covered California expects Contractor to only contract with Providers and hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. To meet this expectation, by contract year 2018, Covered California will work with its QHP Issuers to identify areas of "outlier poor performance" based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with Providers throughout California. For contract year 2019, QHP Issuers will be expected to either exclude those Providers that are "outlier poor performers" on either cost or quality from Covered California Provider networks or to document each year in its application for certification the rationale for continued contracting with each Provider that is identified as a "poor performing outlier" and efforts the Provider is undertaking to improve performance. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuer. QHP Issuer's rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, and plans to transition patients from the care of Providers with poor performance. Such information may be made publicly available by Covered California.

4) Contractor will be required to report each year as part of the annual negotiation and certification process, starting with its application for certification for 2017, how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will be required to include in its application for certification for 2017 and annually thereafter, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

5) While Covered California welcomes QHP Issuers' use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for "tiered" in-network Providers.

1.03 Demonstrating Action on High Cost Providers

Affordability is core to Covered California's mission to expand the availability of insurance coverage and promoting the Triple Aim. The wide variation in unit price and total costs of care

charged by Providers, with some Providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor will be required to report to Covered California as part of its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes:

   (a) The factors it considers in assessing the relative unit prices and total costs of care;

   (b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care) or other factors;

   (c) How such factors are used in the selection of Providers or facilities in networks available to Enrollees; and

   (d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs; and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

2) In its application for certification for 2017, and annually thereafter, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure that contracted Providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include:

   (a) Telemedicine;

   (b) Use of Centers of Excellence; and

   (c) Design of Networks (see Article 1.02)

   (d) Reference Pricing; and

   (e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by consumers.

3) For contract year 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life threatening conditions. Covered California

expects its Contractor to ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in Specialty Pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

1) Contractor must describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:

   (a) Drug Effectiveness Review Project (DERP)

   (b) NCCN Resource Stratification Framework (NCCN-RF)

   (c) NCCN Evidence Blocks (NCCN-EB)

   (d) ASCO Value of Cancer Treatment Options (ASCO- VF)

   (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

   (f) Oregon State Health Evidence Review Commission Prioritization Methodology

   (g) Premera Value-Based Drug Formulary (Premera VBF)

   (h) DrugAbacus (MSKCC) (DAbacus)

   (i) The ICER Value Assessment Framework (ICER-VF)

   (j) Real Endpoints

   (k) Blue Cross/Blue Shield Technology Evaluation Center

   (l) International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

   (m) Other (please identify)

2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone

3) Contractor shall describe how it monitors off-label use of pharmaceuticals and what efforts are undertaken to assure any off-label prescriptions are evidence-based;

4) Contractor must describe how it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

Starting with the application for certification for 2017, Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align Provider and enrollee market-based incentives with delivery system and quality targets.

Contractor agrees to align its QIS with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy and first-year plan for implementing each initiative through the annual certification application submitted to Covered California, which will be used for negotiation purposes during the application process. Contractor understands that the application serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform initiatives.

Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which will include:

(a) The percentage, number and performance of total participating Providers;

(b) The number and percent of Enrollees participating in the initiative;

(c) The number and percent of all the Contractor's covered lives participating in the initiative; and

(d) The results of Contractor's participation in this initiative, including clinical, patient experience and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in two such collaboratives:

(a) CalSIM Maternity Initiative: Sponsored by Covered California, DHCS and CalPERS as well as other major purchasers with support from the California Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated

reductions in maternal and newborn mortality and morbidity. http://www.chhs.ca.gov/PRI/_CalSIM%20Maternity%20Initiative%20WriteUp%20April%202014.pdf (See Article 5, Section 5.03)

(b) Statewide workgroup on Overuse: Sponsored by Covered California, DHCS and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of C-sections, prescription of opioids and low back imaging. http://www.iha.org/grants-projects-reducing-overuse-workgroup.html (See Article 7, Section 7.05)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the application for certification for 2017, and annually thereafter, for negotiation purposes, Contractor will be required to report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

(a) CMMI's Transforming Clinical Practices, administered by:

i. Children's Hospital of Orange County,

ii. LA Care,

iii. National Rural Accountable Care Consortium,

iv. California Quality Collaborative of PBGH, and

v. VHA/UHC Alliance NewCo, Inc.

All five of these collaboratives are coaching accessible, data-driven, team-based care over the course of the grant 2015-2019. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ (See Article 4, section 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety, which between 2012 and 2014 resulted in 87,000 fewer deaths, mostly in 2013-14. (http://www.ahrq.gov/professionals/quality-patient safety/pfp/interimhacrate2014.html See article 5, section 5.02)

Awardees working with California hospitals for 2015-2016 are:

i. Hospital Quality Initiative subsidiary of the California Hospital Association.

ii. Dignity Hospitals,

iii. VHA/UHC, and

iv. Children's Hospitals' Solutions for Patient Safety

v. Premiere, Inc.

(c) 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program

(d) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopedic Association (COA) and PBGH

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

(g) CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(l) Leapfrog

(m) A Federally Qualified Patient Safety Organization such as CHPSO

(n) The IHA Encounter Standardization Project

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

4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, the initiatives Contractor has undertaken to improve routine exchange of timely information with Providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

(a) Notifying Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the

knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

(c) Racial and ethnic self-reported identity collected at every patient contact.

2) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:

(a) Inland Empire Health Information Exchange (IEHIE)

(b) Los Angeles Network for Enhanced Services (LANES)

(c) Orange County Partnership Regional Health Information Organization (OCPRHIO)

(d) San Diego Health Connect

(e) Santa Cruz Health Information Exchange

(f) CalIndex

1.08 Data Aggregation across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payors to more accurately understand the performance of Providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a Provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on Providers through such proposals as a statewide All Payor Claims Database.

Examples include but are not limited to:

(a) The Integrated Health Association (IHA) for Medical Groups

(b) The California Healthcare Performance Information System (CHPI)

(c) The CMS Physician Quality Reporting System

(d) CMS Hospital Compare or

(e) CalHospital Compare

ARTICLE 2
PROVISION AND USE OF DATA AND INFORMATION FOR QUALITY OF CARE

2.01 HEDIS and CAHPS Reporting

Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's oversight of Contractor's QHPs.

2.02 Data Submission Requirements

Contractor and Covered California agree that the assessment of quality and value offered by a QHP to enrollees is dependent on consistent, normalized data, so that the Contractor and Covered California can evaluate the experience of Contractor's membership, and compare that experience to the experience of Enrollees covered by other QHP issuers, and to the Covered California population as a whole. In order to conduct this assessment, Contractor shall provide certain information currently captured in contractor's information systems related to its participation in the Exchange EAS Vendor in a manner consistent to that which Contractor currently provides to its major purchasers.

1) Disclosures to Enterprise Analytics Vendor:

(a) Covered California has entered into a contract with an Enterprise Analytics Vendor ("EAS Vendor") to support its oversight and management of health exchange. EAS Vendor has provided Contractor with a written list of data elements ("EAS Dataset") and a data submission template that defines the data elements and format for transmitting the data. Contractor shall provide EAS Vendor with the data identified in the EAS Dataset on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without formal amendment to this Agreement.

(b) To enable the submission of the EAS Dataset to EAS Vendor, Contractor has executed a Business Associate Agreement ("BAA"), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor. Contractor's obligation to provide any data to EAS Vendor is contingent on a BAA being in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to the submission of the EAS Dataset.

2) Disclosures to Covered California:

(a) EAS Vendor must protect the EAS Dataset submitted to it by Contractor pursuant to the BAA and any other agreements entered into with Contractor, applicable federal and state laws, rules and regulations, including the HIPAA Privacy and Security Rules. Any data extract or report ("EAS Output") provided to Covered California and generated from the EAS Dataset shall at all times be limited to de-identified data. Covered California shall not request any Personally Identifiable Health Information from EAS Vendor or attempt to use the de-identified data it receives from EAS Vendor to re-identify any person.

3) EAS Vendor Designation:

(a) Truven Health Analytics ("Truven") is Covered California's current EAS Vendor. In the event that Covered California terminates its contract with Truven during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to section 12.3 of the Agreement. Any such termination of the agreement with Truven shall excuse any performance of Contractor under this section 2.02 effective on the date of termination of the agreement with Truven until a replacement EAS Vendor is designated.

4) Covered California is a Health Oversight Agency:

(a) Covered California continues to maintain that it operates as a Health Oversight Agency as described by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. As such, Contractor may disclose protected health information to Covered California, or its vendor, in order for Covered California to perform its mandated oversight activities. At such time that Covered California receives technical assistance from the Office for Civil Rights, or otherwise receives guidance from the federal government, that reasonably confirms Covered California's status as a Health Oversight Agency, Contractor shall provide Covered California, or its vendor, with the necessary data elements, including protected health information as permitted by state and federal laws, in order for Covered California to perform its mandated oversight activities.

2.03 eValue8 Submission

For measurement year 2017, Contractor will be required to respond to those eValue8 questions identified and required by Covered California in the Covered California eValue8 Health Plan Request for Information as part of the application for certification for 2019.

Such information will be used by Covered California to evaluate Contractor's performance under the terms of the Quality, Network Management, Delivery System Standards and Improvement Strategy and in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years. The timing, nature and extent of such responses will be established by Covered California based on its evaluation of various quality-related factors.

Contractor's response shall include information relating to all of Contractor's then-current Covered California-based business and any information that reflects California-based business when data on Covered California-specific business is not available. If applicable, Contractor must report data separately for HMO/POS, PPO and EPO product lines.

Contractor will be required to provide Covered California information regarding their quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Health Plan RFI in the annual application for certification. Such information in connection with the evaluation regarding any extension of this Agreement and the recertification process for subsequent years and may include copies of reports used by the Contractor for other purposes.

2.04 Data Measurement Specifications

The measurement specifications for data reporting requirements in this attachment are included in Appendix 2 to this attachment.

ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:

(a) By the end of 2019, Contractor must achieve 80 percent self-identification of racial/ethnic identity for Covered California enrollees.

(b) In the application for certification for 2017, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.

(c) Covered California and Contractor will negotiate annual targets to be reported in the applications for certification for 2018 and beyond.

(d) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.

2) Measures for Improvement:

(a) Disparities in care by racial and ethnic identity and by gender will be reported by QHP Issuers in the annual application for certification based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.

(b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission and ER visit rates) and Depression (HEDIS appropriate use of medications and all-cause ER utilization).

(c) Covered California will consider adding additional measures for plan year 2020 and beyond.

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

1) In the application for certification for 2017, Contractor reported baseline measurements from plan year 2015 on the measures listed in 3.01(2)(a) of this Attachment, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete.

2) Targets for 2019 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include:

1) Income

2) Disability status

3) Sexual orientation

4) Gender identity

5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4
PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the triple aim requires a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Contractor agrees to actively promote the development and use of care models that promote access, care coordination and early identification of at-risk enrollees and consideration of total costs of care. Contractor agrees to design networks and payment models for Providers serving Enrollees to reflect these priorities.

In particular, the Covered California's priority models which align with the CMS requirements under the QIS, are:

1) Effective primary care services, including ensuring that all enrollees have a Primary Care clinician.

2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

3) Integrated Healthcare Models (IHM) or Accountable Care Organizations, such as those referenced by the Berkeley Forum (2013) that coordinate care for patients across conditions, Providers, settings and time, and are paid to deliver good outcomes, quality and patient satisfaction at an affordable cost.

4.01 Primary Care

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinican by January 1, 2017 or within 60 days of effectuation into the plan, whichever is sooner. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support triple aim goals.

1) Contractor agrees to cooperate with Covered California in evaluating various PCMH accreditation and certification programs promulgated by national entities, as well as other frameworks for determining clinical practice transformation, with the goal of adopting a consistent standard definition across covered QHP Issuers for determining which Providers or practices meet the standards for redesigned primary care in Covered

California networks. Covered California and Contractor agree to engage interested stakeholders, including Providers and other purchasers, such as CalPERS, the Department of Health Care Services (DHCS) and private employers, in the process of developing this standard definition in preparation for use in the application for certification for 2018. As part of this effort, Contractor agrees to work with Covered California to limit the reporting burden on Providers.

2) Contractor will be required to describe in its application for certification for 2017, a payment strategy for adoption and progressive expansion among Providers caring for Enrollees, that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the triple aim, including total cost of care.

3) Contractor will be required to report in the application for certification for 2018:

   (a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.

   (b) Based on the data provided in the 2018 Application, Covered California will establish targets for 2019 for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

   (c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.

   (d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

   (e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.03 Integrated Healthcare Models (IHM) or Accountable Care Organizations (ACO)

Covered California places great importance on the adoption and expansion of integrated, coordinated and accountable systems of care and is adopting a modified version of the CalPERS definition for Integrated HealthCare Models also known as Accountable Care Organizations (ACOs):

1) The IHM is defined as:

(a) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary Providers.

(b) Having at least Level three (3) integration, as defined by the Institutes of Medicine (IOM), of certified Electronic Health Record (EHR) technology in both a hospital inpatient and ambulatory setting provided either by a Provider organization or by Contractor:

i. Ambulatory level of integration will include, at minimum, electronic charts, a data repository of lab results, connectivity to hospitals, partial or operational point of care technology, electronic assistance for ordering, computerized disease registries (CDR), and e-mail.

ii. Hospital inpatient level of integration will include, at minimum, lab, radiology, pharmacy, CDR, clinical decision support, and prescription documentation.

iii. There must be Stage two (2) (Advanced Clinical Processes) of Meaningful Use of the certified EHR within the IHM including:

a. Health Information and Data,

b. Results Management,

c. Order Entry/Management,

d. Clinical Decision Support

e. Electronic Communications and Connectivity, and

f. Patient Support.

(c) Having combined risk sharing arrangements and incentives between Contractor and Providers, and among Providers across specialties and institutional boundaries, holding the IHM accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, Contractors shall be aware of their obligations in the Health and Safety Code and Insurance Code to ensure that Providers have the capacity to manage the risk.

2) Contractor must provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in Article 4.03(1), including the number and percent of Enrollees who are managed under IHMs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years..

3) Targets for 2017-2019 for the percentage of Enrollees who select or are attributed to IHMs will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data is to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

4.04 Mental and Behavioral Health

Covered California and Contractor recognize the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to Enrollees.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

1) Making behavioral health services available to Enrollees;

2) How it is integrating Behavioral Health Services with Medical Services; and

3) Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and IHM models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

4.05 Telemedicine and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telemedicine and remote home monitoring. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Reporting requirements will be met through eValue8 in the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must include whether these models are implemented in association with PCMH and IHM models or are independently implemented.

ARTICLE 5
HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that incrementally places at least six percent of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent of reimbursement by January 1, 2019 with a plan for satisfying future increases in reimbursement, four percent of reimbursement by January 1, 2021 and six percent by January 1, 2023. Contractor may structure this strategy according to its own priorities such as:

   (a) The extent to which the payments "at risk" take the form of bonuses, withholds or other penalties; or

   (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.

   (c) Contract arrangements with hospitals that participate in Integrated Healthcare Models or Accountable Care Organizations, whether sponsored by the QHP Issuer or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.

2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

   a) Long Term Care hospitals

   b) Inpatient Psychiatric hospitals

c) Rehabilitation hospitals

d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:

(a) Amount, structure and metrics for its hospital payment strategy;

(b) The percent of network hospitals operating under contracts reflecting this payment methodology;

(c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and

(d) The dollars and percent, or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value must be distinct from shared-risk and performance payments to hospitalization related to participation in IHMs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

5.02 Hospital Patient Safety

1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:

(a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

2) Contractor will be required to report in its annual application for certification, baseline rates of specified HACs for each of its network hospitals. In order to obtain the most reliable measurement, minimize the burden on hospitals and in the interest of promoting common measurement, Contractor must employ best efforts to base this report on clinical data, such as is reported by hospitals to the National Healthcare Safety Network (NHSN),

California Department of Public Health (CDPH) and to CMS under the Partnership for Patients initiative. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

3) Prior to the application for certification for 2018, target rates for 2019 and for annual intermediate milestones for each HAC measured at each hospital will be established by Covered California, based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

4) Covered California has identified an initial set of HACs for focus in 2017. Certain HACs may be substituted for others in the event that a common data source cannot be found. The decision to substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the 2017 hospital safety initiatives are listed below:

   (a) Catheter Associated Urinary Tract Infection (CAUTI);

   (b) Central Line Associated Blood Stream Infection (CLABSI);

   (c) Surgical Site Infection (SSI) with focus on colon;

   (d) Adverse Drug Events (ADE) with first-year focus on opioid overuse; and

   (e) Clostridium difficile colitis (C. Diff) infection.

5) The subject HACs may be revised in future years. Covered California expects to include additional ADEs including hypoglycemia and inappropriate use of blood thinners as well as Sepsis Mortality at such time as the standardized CMS definition and measurement strategy has been tested and validated.

6) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation, by year end 2017, Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. For contract year 2019, as detailed in Article 1.02(3), Contractors must either exclude hospitals that demonstrate outlier poor performance on safety from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance.

5.03 Appropriate Use of C-Sections

Contractor agrees to actively participate in the statewide effort to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS and CalPERS as well as major employers is coordinated with CalSIM, and has adopted the goal of reducing NTSV (Nulliparous, Term Singleton, Vertex) C-section rates to meet or exceed the national Healthy

People 2020 target of 23.9 percent for each hospital in the state by 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to enroll in the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC).

2) Annually report in its application for certification the C-section rate for NTSV deliveries and the overall C-Section rate for each of its network hospitals for the hospital's entire census. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Contractor must report on its design and the percent of hospitals contracted under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, As detailed in Article 1.02(3), Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 percent from Provider networks or to document each year in its application for certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9 percent and efforts the hospital is undertaking to improve its performance.

ARTICLE 6
POPULATION HEALTH: PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contractor recognize that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of Enrollee health. Contractor and Covered California shall identify ways to increase access and coordination of care and work collaboratively to achieve these objectives.

6.01 Health and Wellness Services

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

1) Necessary preventive services appropriate for each Enrollee. Contractor must report utilization to Covered California on the number and percent of Enrollees who take advantage of their wellness benefit.

2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.

3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.

4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:

   (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and

   (b) Processes to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the Providers.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California will establish targets for 2018 and annual milestones thereafter for the percent of the population that uses annual preventive visits based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders

6.02 Community Health and Wellness Promotion

Covered California and Contractor recognize that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments and the promotion of healthy behaviors across the community. Contractor is encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

Such programs may include:

1) Partnerships with local, state or federal public health departments such as Let's Get Healthy California;

2) CMS Accountable Health Communities;

3) Voluntary health organizations which operate preventive and other health programs such as CalFresh; and

4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain, use, and protect from disclosure individual information about Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s).In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the plan, and that participating in the assessment is optional.

6.04 Reporting to and Collaborating with Covered California Regarding Health Status

Contractor shall provide to Covered California, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Enrollees' health status. Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to Covered California its process to monitor and track Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to Contractor care management and chronic condition program(s) as defined in Section 6.05, for the necessary intervention. Contractor shall annually report to Covered California the number of Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition

Contractor shall have an evaluation and transition plan in place for the Enrollees transitioning into or from employer-sponsored insurance, Medi-Cal, Medicare, or other insurance coverage who require therapeutic Provider and formulary transitions. Contractor shall also support transitions in the reverse direction. The plan must include the following:

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

2) Clear processes to communicate Enrollee's continued treatment using a specific therapy, specific drug or a specific Provider when no equivalent is available in-network;

3) Where possible, advance notification and understanding of out-of-network Provider status for treating and prescribing physicians; and

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

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor agrees to support disease management activities at the plan or health care Provider level that meet standards of accrediting programs such as NCQA. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation may include the following:

1) Methods to identify and target At-Risk Enrollees;

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

3) Communication plan for known At-Risk Enrollees to receive information prior to Provider visit, including the provision of culturally and linguistically appropriate communication;

4) Process to update At-Risk Enrollee medical history in Contractor's maintained Enrollee health profile;

5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP.

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

7) Care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include "tools" and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;

8) Data on number of Enrollees identified and types of services provided.

ARTICLE 7

PATIENT-CENTERED INFORMATION AND SUPPORT

Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer access to care.

Covered California and Contractor agree that valid, reliable, and actionable information relating to the cost and quality of healthcare services is important to Enrollees, Covered California, and Providers.

Thus, Covered California expects that Contractor will participate in activities necessary to provide this information to consumers. The specifics of this phased approach are described in Section 7.01 below.

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the application for certification for 2017, Contractor will have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:

   (a) Cost information:

      i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.

      ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

      iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

   (b) Quality information:

      i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.

      ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the

Patient Charter for Physician Performance Measurement.

iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. The Department of Insurance Healthcare Compare (www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm)

c. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

d. CMS Physician Quality Reporting System (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/)

iv. In addition, Contractor must recognize California hospitals that have achieved target rates for HACs and NTSV C-Section utilization as defined in Article 5, Sections 5.02 and 5.03.

(c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that includes accumulations of expenses applicable to deductible and out-of-pocket maximums.

(d) Contractor agrees to monitor care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care out of network intentionally.

(e) If Contractor enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

2) Contractor will be required in its annual application for certification to:

(a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.

(b) Report user experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating.

(c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for exchange-only business and any required data will be submitted as part of Contractor's annual application for certification

7.02 Enrollee Personalized Health Record Information

1) In its Application for Certification for 2017, Contractor will have reported for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported its plan to provide such access through such tools as a Personal Health Record (PHR) or other "patient portal".

2) The content of such PHRs includes: medical records, billing and payment records, insurance information, clinical laboratory test results, medical images such as X-rays, wellness and disease management program files, clinical case notes, and other information used to make decisions about individuals.

3) Covered California will establish targets for 2019 and annual milestones thereafter for Enrollee use of personal health information based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor will provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03. Enrollee Shared Decision-Making

Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their Provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

Contractor agrees to promote and encourage patient engagement in shared decision-making with contracted Providers.

1) Contractor will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.

2) Contractor will be required to report in its annual application for certification the percentage of Enrollees with identified health conditions above who received information

that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan.

3) Contractor will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.

4) These reports will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the recertification process for subsequent years.

7.04 Reducing Overuse through Choosing Wisely

Contractor shall participate in the statewide workgroup on Overuse sponsored by Covered California, DHCS and CalPERS. This multi-stakeholder work group facilitated by IHA, will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of:

1) C- Sections for low risk (NTSV) deliveries;
2) Opioid overuse and misuse; and
3) Imaging for low back pain.

The mechanism for reduction of NTSV C-Sections will be participation in the California State Initiative Model (CalSIM) Maternity Care Initiative, with the target of ensuring all network hospitals achieve rates of 23.9 percent or less by 2020. (See section 5.03)

Improvement strategies and targets for 2019 as well as for annual intermediate milestones in reductions of overuse of opioids and imaging for low back pain will be established by Covered California in collaboration with other stakeholders participating in the workgroup based on national benchmarks, analysis of variation in California performance and best existing science of quality improvement and effective engagement of stakeholders.

ARTICLE 8
PAYMENT INCENTIVES TO PROMOTE HIGHER VALUE CARE

8.01 Reward-based Consumer Incentive Programs

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

8.02 Value-Based Reimbursement Inventory and Performance

Contractor agrees to implement value-based reimbursement methodologies to Providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures and must include the Contractor's entire book of business with the Provider.

1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:

   (a) Advanced Primary Care or Patient-Centered Medical Homes (4.02)

   (b) Integrated Healthcare Models (4.03)

   (c) Appropriate use of C-sections (5.03)

   (d) Hospital Patient Safety (5.02)

2) In addition to the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:

   (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

   (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in service areas that have the potential to improve care and generate savings for Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission

1) Contractor agrees to provide information to Covered California pursuant to this Article 8, understanding that Covered California will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

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

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

4) Contractor must annually report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the Covered California eValue8 RFI and CPR's Payment Reform Evaluation Framework.

ARTICLE 9
ACCREDITATION

1) Contractor agrees to maintain a current accreditation throughout the term of the Agreement from one of the following accrediting bodies: (i) Utilization Review Accreditation Commission (URAC); (ii) National Committee on Quality Assurance (NCQA); (iii) Accreditation Association for Ambulatory Health Care (AAAHC). Contractor shall authorize the accrediting agency to provide information and data to Covered California relating to Contractor's accreditation, including, the most recent accreditation survey and other data and information maintained by the accrediting agency as required under 45 C.F.R. § 156.275.

2) Contractor shall be currently accredited and maintain its NCQA, URAC or AAAHC accreditation throughout the term of the Agreement. Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review. Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall provide Covered California with a copy of the Assessment Report within forty-five (45) days of report receipt.

3) If Contractor receives a rating of less than "accredited" in any category, loses an accreditation or fails to maintain a current and up to date accreditation, Contractor shall notify Covered California within ten (10) business days of such rating change and must provide Covered California with all corrective action(s). Contractor will implement strategies to raise Contractor's rating to a level of at least "accredited" or to reinstate accreditation. Contractor will submit a written corrective action plan (CAP) to Covered California within forty-five 45 days of receiving its initial notification of the change in category ratings.

4) Following the initial submission of the CAPs, Contractor shall provide a written report to Covered California on at least a quarterly basis regarding the status and progress of the submitted CAP. Contractor shall request a follow-up review by the accreditation entity at the end of twelve (12) months and submit a copy of the follow-up Assessment Report to Covered California within thirty (30) days of receipt, if applicable.

5) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this Agreement , suspend enrollment in Contractor's QHPs or avail itself of any other remedies in this Agreement, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation.

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

Quality, Network Management and Delivery System Standards

Glossary of Key Terms

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

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

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

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

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

Enrollees – Those individuals with coverage through the Issuer received through Covered California.

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

is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Health Disparities - Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Health Equity - Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1978) Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a “gatekeeper” or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, Pediatrics and Family Medicine as primary care specialties.

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

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

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

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

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive

programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

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

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

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

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

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

Appendix 1 to Attachment 7

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated		Not required at this time. Blank Fill.
2	CC_SubscriberID	10	29	20	Character	Unique code assigned by CC to the		
3	Enrollee SSN	30	38	9	Character	Member's Social Security Number		Not required at this time. Blank Fill.
4	CC_MemberID	39	58	20	Character	Unique code assigned by CC to the		
5	Plan_MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Not required at this time. Blank Fill.
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Not required at this time. Blank Fill.
7	Capitation Amount	99	108	10	Numeric	The pre-paid amount paid to plans or providers under risk-based managed		Format 9(7)v99 (2 - digit, implied decimal)
8	Capitation Type Code	109	109	1	Character	This field identifies the type of capitation payment record: • 1 – Professional • 2 – Facility • 3 – Mental Health • 4 – Drug • 5 – Dental • 6 – Vision • 7 – Hearing • 8 – Blended		
9	Date Paid	110	119	10	Date	The date the transaction was paid.		MM/DD/CCYY Format
10	Date of Service	120	129	10	Date	The date/period of service for the transaction. If the period of service is a month, this can be populated with the		MM/DD/CCYY Format
11	Gender Code	130	130	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
12	Date of Birth	131	140	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
13	Adjustment Type Code	141	141	1	Character	Client-specific code for the claim adjustment type.	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
14	Provider Type Code	142	144	3	Character	This field contains the provider specialty code.	Yes	
15	Provider ID TIN	145	157	13	Character	The unique identifier for the provider. Providers include facilities, physicians, PCPs, pharmacies, and professionals.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
16	Provider NPI	158	167	10	Character	The National Provider Identifier for the provider.		
17	Withhold Amount	168	177	10	Numeric	Withheld Capitation Payment		

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
18	Filler	178	699	522	Character	Reserved for future use		Fill with blanks
19	Record Type	700	700	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Standard Layout								
Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	Data Supplier Comments
Standard Truven Health Analytics Fields								
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.	
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.	
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.	
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file	
5	Filler	45	699	655	Character	Reserved for future use	Fill with Blanks	
6	Record Type	700	700	1	Character	Record Type Identifier	Hard Code 'T'	
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row								

TRUVEN HEALTH ANALYTICS

Covered California EAS
Enrollment Functional Specification
03/15/2016

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
3/15/2016	Dan Lopez	Field lenghts of race code increased to 3 bytes, added new field, Cost Share Reduction Amount
6/12/2015	Dan Lopez	Update after all data summits
5/26/2015	Katie Andrada-Bacorn	Update after initial data summit
5/19/2015	Dan Lopez	Updated after meeting with Covered CA and Cal HEERS
5/11/2015	Dan Lopez	initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly enrollment file for plan participants.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2014 -current. Truven Health Analytics will expect to receive one file for every month from January 1, 2014 to current. Each file will contain one record per member, per month. Ongoing file submissions would include one record for each member for the latest month only.

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Policy Holder ID we would like to have information copied down from the policy holder to the enrollee record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person.

For each field, Truven Health Analytics has noted one of the three values below in the right-most column.

ENROLLEE-SPECIFIC (MEMBER SPECIFIC)	Information relevant to the enrollee (e.g. Date of Birth, Truven Health Analytics would like each enrollee's date of birth). Please populate on each record with the information specific to that enrollee.
POLICY-HOLDER-ONLY (SUBSCRIBER ONLY)	Information relevant to the policy holder that Truven Health Analytics would like on the contract holder, i.e. not copied onto the enrollee's records.
POLICY-HOLDER-SPECIFIC (SUBSCRIBER SPECIFIC)	Information relevant to the policy holder, but needs to be copied down to the enrollee. Please populate on each record with the information that has been copied from the policy holder.

***Note: Selections of Rows or Columns for each action must be made **after** pressing the de

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
1	Enrollment Snapshot Month	1	10	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
2	Date of Birth	11	20	10	Date	MM/DD/CCYY format				Enrollee-Specific
3	Date of Death	21	30	10	Date	Blank Fill this field at this time		X		Enrollee-Specific
4	Subscriber SSN	31	39	9	Character	Blank Fill this field at this time		X		Policy Holder-Specific
5	CC Subscriber ID	40	59	20	Character					Policy Holder-Specific
6	Enrollee/member SSN	60	68	9	Character	Blank Fill this field at this time		X		Enrollee-Specific
7	CC Member ID	69	88	20	Character			X		Enrollee-Specific
8	Plan Member ID	89	108	20	Character	Blank Fill this field at this time		X		Enrollee-Specific
9	Policy ID	109	128	20	Character	Blank Fill this field at this time				Policy -holder specific
10	Enrollee First Name	129	188	60	Character	Blank Fill this field at this time		X		Enrollee-Specific
11	Enrollee Last Name	189	248	60	Character	Blank Fill this field at this time		X		Enrollee-Specific
12	Enrollee Middle Initial	249	249	1	Character	Blank Fill this field at this time				Enrollee-Specific
13	Enrollment End Reason Code	250	253	4	Character	Reason codes will be identified in the Data Dictionary.			Yes	Enrollee-specific
14	Address 1	254	303	50	Character	Blank Fill this field at this time		X		Enrollee-Specific
15	Address 2	304	333	30	Character	Blank Fill this field at this time		X		Enrollee-Specific
16	City	334	363	30	Character			X		Enrollee-Specific
17	State Code	364	365	2	Character			X		Enrollee-Specific
18	Zip Code (5 digit)	366	370	5	Character			X		Enrollee-Specific
19	Zip Code plus 4 (last 4)	371	374	4	Character	Blank Fill this field at this time				Enrollee-Specific
20	County Code	375	379	5	Character					Enrollee-Specific
21	Gender Code	380	380	1	Character	M or F		X		Enrollee-Specific
22	Relationship Code	381	385	5	Character	Relationship code values will be identified in the **Data Dictionary**.		X	Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
23	Race 1 Code	386	388	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
24	Race 2 Code	389	391	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
25	Race 3 Code	392	394	3	Character	Race code values will be identified in the **Data Dictionary.** 3/15/16 -Size of field expanded to 3 bytes		X	Yes	Enrollee-Specific
26	Ethnicity 1 Code	395	400	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
27	Ethnicity 2 Code	401	406	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
28	Ethnicity 3 Code	407	412	6	Character	Ethnicity code values will be identified in the **Data Dictionary.**		X	Yes	Enrollee-Specific
29	Language Written Code	413	416	4	Character	values will be identified in the **Data Dictionary**.			Yes	Enrollee-Specific
30	Language Spoken Code	417	420	4	Character	values will be identified in the **Data Dictionary**.			Yes	Enrollee-Specific
31	Coverage Start Date	421	430	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
32	Coverage End Date	431	440	10	Date	MM/DD/CCYY Format		X		Enrollee-Specific
33	Coverage Indicator Dental	441	441	1	Character	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"		X		Enrollee-Specific
34	Coverage Indicator Drug	442	442	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
35	Coverage Indicator Hearing	443	443	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
36	Coverage Indicator Medical	444	444	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
37	Coverage Indicator MHSA	445	445	1	Character	Standard values: Y = Have coverage, N = Do not have coverage All Hard code to "Y"		X		Enrollee-Specific
38	Coverage Indicator Vision	446	446	1	Character	Standard values: Y = Have coverage, N = Do not have coverage Children Only Hard code to "N"		X		Enrollee-Specific
39	PCP Type Code	447	450	4	Character	PCP Type code values will be identified in the **Data Dictionary**. Field is not available, Truven to impute PCP		X	Yes	Enrollee-Specific
40	PCP Provider ID TIN	451	463	13	Character	For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.		X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
41	Gross Premium	464	473	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contribution) as this will be calculated within the Truven Health Analytics product. It should be populated only on employee records for those employees enrolled in fully-insured medical plans. On all other records this field should be zero filled.		X		Policy Holder/Contract Holder Only
42	Net Premium	474	483	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).		X		Policy Holder/Contract Holder Only
43	Subsidy Amount	484	493	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).		X		Policy Holder/Contract Holder Only
44	Product Type/Medical Plan Type	494	497	4	Character	Indemnity, HMO, PPO, FFS, POS, HDHP, CDHP, etc.		X	Yes	Enrollee-specific
45	Medical Fully Insured Indicator	498	498	1	Character	Y = Yes N = No hard code to "Y"		X		Enrollee-specific
46	Drug Fully Insured Indicator	499	499	1	Character	Y = Yes N = No hard code to "Y"		X		Enrollee-specific
47	HIOS Plan Code	500	515	16	Character			X		Enrollee-Specific
48	Rating Region Code	516	520	5	Character			X		Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
49	Policy Structure Code/Coverage Tier Code	521	524	4	Character	Customer-specific values will be identified in the **Data Dictionary**.		X	Yes	Policy Holder-Specific
50	Dental Plan Code	525	530	6	Character	This will currently be blank-filled from the data supplier, Truven to populate with the same code from Medical. It's desirable to have a plan code explicitly identifying "Opt-outs".		X	Yes	Enrollee-Specific
51	Dental Policy Structure Code/Coverage Tier Code	531	534	4	Character	values will be identified in the **Data Dictionary**.		X	Yes	Enrollee-Specific
52	Monthly Policy Holder Dental Contribution	535	544	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).		X		Policy Holder/Contract Holder Only
53	Monthly Dental Premium	545	554	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Truven Health Analytics product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled.		X		Policy Holder/Contract Holder Only
54	Vision Plan Code	555	560	6	Character	Vision plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "Opt-outs". **This field will be initially set to blanks**		X	Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
55	Vision Policy Structure Code/Coverage Tier Code	561	564	4	Character	values will be identified in the **Data Dictionary**. **This field will be initially set to blanks**		X	Yes	Enrollee-Specific
56	Monthly Policy Holder Vision Contribution	565	574	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on dependent records). **This field will be initially set to blanks**		X		Policy Holder/Contract Holder Only
57	Monthly Vision Premium	575	584	10	Numeric	Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid by the government for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Truven Health Analytics product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled. **This field will be initially set to blanks**		X		Policy Holder/Contract Holder Only
58	SHOP Employee Status Code	585	589	5	Character	Employee Status code values will be identified in the **Data Dictionary**. 8/26 - not available in Sharp file.	X	X	Yes	Policy Holder-Specific
59	SHOP Employee Medicare Eligible Indicator	590	590	1	Character	Y = Yes N -No 8/26 - not available in Sharp file.	X			Policy Holder-Specific
60	SHOP Part-Time/Full-time Indicator	591	591	1	Character	P = Part-time F - Full-time 8/26 - not available in Sharp file.	X			Policy Holder-Specific
61	Plan Group Number	592	611	20	Character		X	X	Yes	Enrollee-Specific
62	Plan Group Suffix	612	616	5	Character		X	X	Yes	Enrollee-Specific
63	Industry Classification Code	617	622	6	Character	HPID or SHOP	X	X		Policy Holder-Specific

Field Number	Field Name	Start	End	Length	Type	Data Supplier Instructions/Notes	SHOP Only	Advantage Field	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Truven Health Analytics Fields										
64	Cost Sharing Reduction	623	632	10	Numeric	The cost sharing redcution amount. Note: If available, this should be the actual CSR, which may not be the same as the CSR amount on the 834.				Policy Holder-Specific
65	Filler	633	999	367	Character	Fill with blanks				Enrollee-Specific
66	Record Type	1000	1000	1	Character	Hard Code to "D"				Enrollee-Specific
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row										

Eligibility Functional Specifications for File Layout
--- Trailer Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Eligibility Start Date	1	10	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2015 This will represent the 1st day of the month for which data is provided.
2	Eligibility End Date	11	20	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2015 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Filler	31	999	969	Character	Reserved for future use	Fill with Blanks
5	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code 'T'

TRUVEN HEALTH ANALYTICS

Covered California EAS
Medical Functional Specification
06/15/2015

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
6/12/2015	Dan Lopez	Finalized version after all data summits
6/8/2015	Katie Andrada-Bacorn	Revised after initial data summit
5/21/2015	Dan Lopez	initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a medical claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

DENIED CLAIMS

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:

- **Fully denied claim** : The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- **Partially denied claim :** The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

DEFINITIONS

- **Fee-for-service claims:** Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records:** Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data:** Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-04 claim form.
- **Professional Data:** Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents:** Financial amounts for services rendered under a capitated arrangement found within encounter records.

DISCUSSION ITEMS

- If both fee-for-service claims and encounter records are included on the data file, Truven Health will rely on the data supplier to explain how to differentiate them, preferably using the field Capitated Service Indicator.
- If encounter records contain fee-for-service equivalents, it is essential for Truven Health to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Truven Health will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG. It is our preference if the supplier can apply a factor so that the financials are spread across the lines based on the service rendered.

Claim is paid based on the DRG and Net Payment for the entire claim is $3,632.00; financials are applied across lines

CLAIM LEVEL INFORMATION				SERVICE LEVEL DETAIL				
Claim Id	Provider Id	DRG	Provider Type	Line Number	Revenue Code	Service Count	Allowed Amount	Net Payment
11111	121212121	177	25	1	120	2	$ 2,500.00	$ 2,000.00
11111	121212121	177	25	2	250	1	$ 115.00	$ 100.00
11111	121212121	177	25	3	720	10	$ 1,800.00	$ 1,532.00

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

DISCUSSION ITEMS - PROVIDER

- Truven Health requires unique provider identifiers and associated names. Truven Health would like both the identifier and the name to be specific to each provider, rather than group level information. TAXID is preferred for the identifier.
- If providers within group practices use a single TAXID, Truven Health would prefer an additional qualifier that would make each identifier and name unique.
- If only the group name is available with the associated TIN, and a qualifier is not available, Truven Health prefers another identifier for professional claims and the TAXID for the facility claims. NPI is preferred for the alternate identifier. In this case the TAXID is still requested in addition to the NPI or alternate identifier.

Provider Example 1

When providers in group practices use the same TAXID, a qualifier is needed to insure unique provider names.

Claim ID	TAXID	Qualifier	Provider Name	Prov Type	Service Count	Net Payment
11111	121212121	2222	Dr. Brown	25	2	$ 2,000.00
22222	121212121	3333	Dr. Smith	35	1	$ 100.00

Provider Example 2

The following is an example of what is not desired.

Claim ID	TAXID	Provider Name	Prov Type	Svc Count	Net Payment
11111	121212121	Dr. Brown	25	2	$ 2,000.00
22222	121212121	Dr. Smith	35	1	$ 100.00
33333	232323232	XYZ	25	1	$ 125.00
22222	232323232	XYZ	35	1	$ 110.00

Provider Example 3

When only the groups name is available with TAXID, NPI is requested in addition to TAXID.

Professional

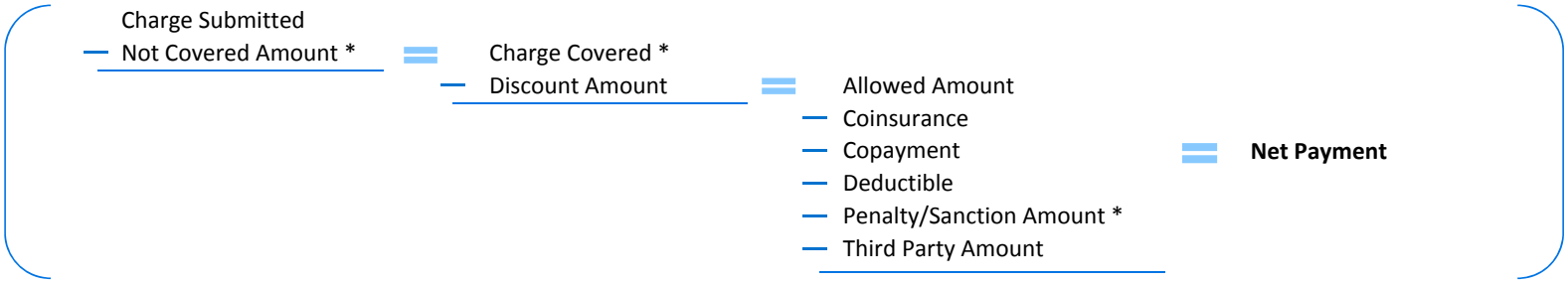
Claim ID	TAXID	Group Name	NPI	Prov Name	Prov Type	Svc Count	Net Payment
11111	121212121	XYZ Pediatrics	2222222222	Dr Brown	25	2	$ 2,000.00
22222	121212121	XYZ Pediatrics	3333333333	Dr Smith	35	1	$ 100.00

Facility

Claim ID	TAXID	NPI	Provider Name	Prov Type	Rev Code	Net Payment
11111	343434343	22222222222	University Hospital	1	110	$ 2,000.00
22222	454545454	33333333333	University Children's Hospital	1	120	$ 100.00

FINANCIAL RELATIONSHIP

Truven Health defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Truven Health defines these as follows:

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

A financial **adjustment** is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well. The original and adjustment need not appear in the same file.

After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

FACILITY RECORD CONTENT

- The standard UB-04 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

One facility claim with three service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Revenue Code**	**Service Count**	**Net Payment**
11111	121212121	25	1	120	2	$ 2,000.00
11111	121212121	25	2	250	1	$ 100.00
11111	121212121	25	3	720	10	$ 1,532.00

PROFESSIONAL RECORD CONTENT

Truven Health does not store separate header/claim-level and detail/service-level information for professional claims. Truven Health requires the following:

- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

One professional claim with two service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Procedure**	**Service Count**	**Net Payment**
13331	621262121	51	1	99201	1	$ 100.00
13331	621262121	51	2	99175	1	$ 150.00

Medical Functional Specifications for File Layout

--- Detail Layout ---

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		Blank Fill this field at this time
2	CC Subscriber ID	10	29	20	Character	The subscriber ID as assigned by Covered California		
3	Enrollee/member SSN	30	38	9	Character	Member's Social Security Number		Blank Fill this field at this time
4	CC Member ID	39	58	20	Character	The member ID as assigned by Covered California		
5	Plan Member ID	59	78	20	Character	The member ID as assigned by the plan		Blank Fill this field at this time
6	Policy ID	79	98	20	Character	The policy number of the policy-holder		Blank Fill this field at this time
7	Rendering Provider ID	99	111	13	Character	The unique identifier for the provider of service.		This is the unique provider ID of the health plan
8	Rendering Provider TIN	112	120	9	Character	The federal tax ID of the provider of service. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
9	Rendering Provider NPI	121	130	10	Character	The National Provider ID number for the provider of service..		
10	Rendering Provider First Name	131	160	30	Character	The description or name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
11	Rendering Provider Last Name	161	190	30	Character	The last name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
12	Rendering Provider Middle Initial	191	191	1	Character	The middle initial corresponding to the servicing Provider ID.		
13	Rendering Provider Address 1	192	241	50	Character	The current street address1 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
14	Rendering Provider Address 2	242	271	30	Character	The current street address2 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
15	Rendering Provider City	272	301	30	Character	The current city of the provider of service.		
16	Rendering Provider State	302	303	2	Character	The current state of the provider of service.		
17	Rendering Provider County Code	304	308	5	Character	FIPS State/County code of the servicing provider		
18	Rendering Provider Zip Code	309	313	5	Character	The 5-digit zip code corresponding to the servicing Provider ID		Provider Location zip code
19	Rendering Provider Zip Plus 4 Code	314	317	4	Character	The 4 digit zip code extension code of the servicing provider		
20	Rendering Provider Type Code Claim	318	321	4	Character	Client-specific code for the provider type on the claim record	Yes	Provider Type codes are further defined in the **Data Dictionary**
21	Referring Provider ID	322	334	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		This is the unique provider ID of the health plan
22	Referring Provider TIN	335	343	9	Character	The federal tax ID of the Referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
23	Referring Provider NPI	344	353	10	Character	The National Provider ID number for the Referring provider.		
24	Referring Provider First Name	354	383	30	Character	The description or name corresponding to the Refering Provider ID.		
25	Referring Provider Last Name	384	413	30	Character	The last name corresponding to the Provider ID.		
26	Referring Provider Middle Initial	414	414	1	Character	The middle initial corresponding to the Refering Provider ID.		
27	Referring Provider Zip Code	415	419	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
28	Referring Provider Zip Plus 4 Code	420	423	4	Character	The 4 digit zip code extension code of the referring provider		
29	Billing Provider ID	424	436	13	Character	The unique ID number of the Billing provider.		This is the unique provider ID of the health plan
30	Billing Provider TIN	437	445	9	Character	The federal tax ID of the billing provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
31	Billing Provider NPI	446	455	10	Character	The National Provider ID number for the billing provider.		
32	Attending Provider ID	456	468	13	Character	The unique ID number of the attending provider.		This is the unique provider ID of the health plan
33	Attending Provider TIN	469	477	9	Character	The federal tax ID of the attending provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
34	Attending Provider NPI	478	487	10	Character	The National Provider ID number for the attending provider.		
35	PCP Provider ID	488	500	13	Character	The unique ID number of the PCP provider.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
36	PCP Provider TIN	501	509	9	Character	The federal tax ID of the PCP provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
37	PCP Provider NPI	510	519	10	Character	The National Provider ID number for the PCP provider.		
38	PCP Responsibility Indicator	520	520	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
39	Adjustment Type Code	521	521	1	Character	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
40	Allowed Amount	522	531	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
41	Bill Type Code UB	532	535	4	Character	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	See Notes	Bill Type values will be identified in the Data Dictionary only if standard codes are not used.
42	Capitated Service Indicator	536	536	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
43	Charge Submitted	537	546	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
44	Claim ID	547	596	50	Character	The client-specific identifier of the claim.		
45	Claim Type Code	597	599	3	Character	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the **Data Dictionary**.
46	Coinsurance	600	609	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
47	Copayment	610	619	10	Numeric	The copayment paid by the subscriber as specified by the plan provision.		
48	Date of Birth	620	629	10	Date	Birth date of the person		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
49	Date of First Service	630	639	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY Format
50	Date of Last Service	640	649	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY Format
51	Date of Service Facility Detail	650	659	10	Date	The date of service for the facility detail record.		MM/DD/CCYY Format
52	Date Paid	660	669	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
53	Days Stay	670	675	6	Numeric	The number of inpatient days for the facility claim.		
54	Deductible	676	685	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
55	Diagnosis Code Principal	686	693	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
56	Diagnosis Code 2	694	701	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
57	Diagnosis Code 3	702	709	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
58	Diagnosis Code 4	710	717	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
59	Diagnosis Code 5	718	725	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
60	Diagnosis Code 6	726	733	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
61	Diagnosis Code 7	734	741	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
62	Diagnosis Code 8	742	749	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
63	Diagnosis Code 9	750	757	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
64	Diagnosis Code 10	758	765	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
65	Diagnosis Code 11	766	773	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
66	Diagnosis Code 12	774	781	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
67	Diagnosis Code 13	782	789	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
68	Diagnosis Code 14	790	797	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
69	Diagnosis Code 15	798	805	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
70	Diagnosis Code 16	806	813	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
71	Diagnosis Code 17	814	821	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
72	Diagnosis Code 18	822	829	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
73	Diagnosis Code 19	830	837	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
74	Diagnosis Code 20	838	845	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
75	Diagnosis Code 21	846	853	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
76	Diagnosis Code 22	854	861	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
77	Diagnosis Code 23	862	869	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
78	Diagnosis Code 24	870	877	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
79	Diagnosis Code 25	878	885	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
80	Discharge Status Code UB	886	887	2	Numeric	The UB-04 standard patient status code, indicating disposition at the time of billing.		
81	Discount Amount	888	897	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
82	Gender Code	898	898	1	Character	Gender of the person.		M or F The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility
83	Line Number	899	900	2	Numeric	The detail line number for the service on the claim		
84	Net Payment	901	910	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
85	Network Paid Indicator	911	911	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
86	Network Provider Indicator	912	912	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		"Y" or "N"
87	Place of Service Code	913	914	2	Character	Client-specific code for the place of service.	See Notes	Truven prefers the CMS place of service values. Place of Service values will be identified in the **Data Dictionary** only if non-standard values are used.
88	Procedure Code	915	921	7	Character	The procedure code for the service record. Length expanded from 5 to 7 for future use.		CPT/HCPCS codes.
89	Procedure Code UB Surg 1	922	928	7	Character	The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
90	Procedure Code UB Surg 2	929	935	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
91	Procedure Code UB Surg 3	936	942	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
92	Procedure Code UB Surg 4	943	949	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
93	Procedure Code UB Surg 5	950	956	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
94	Procedure Code UB Surg 6	957	963	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
95	Procedure Code UB Surg 7	964	970	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
96	Procedure Code UB Surg 8	971	977	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
97	Procedure Code UB Surg 9	978	984	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
98	Procedure Code UB Surg 10	985	991	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
99	Procedure Code UB Surg 11	992	998	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
100	Procedure Code UB Surg 12	999	1005	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
101	Procedure Code UB Surg 13	1006	1012	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
102	Procedure Code UB Surg 14	1013	1019	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
103	Procedure Code UB Surg 15	1020	1026	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
104	Procedure Code UB Surg 16	1027	1033	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
105	Procedure Code UB Surg 17	1034	1040	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
106	Procedure Code UB Surg 18	1041	1047	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
107	Procedure Code UB Surg 19	1048	1054	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
108	Procedure Code UB Surg 20	1055	1061	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
109	Procedure Code UB Surg 21	1062	1068	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
110	Procedure Code UB Surg 22	1069	1075	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
111	Procedure Code UB Surg 23	1076	1082	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
112	Procedure Code UB Surg 24	1083	1089	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
113	Procedure Code UB Surg 25	1090	1096	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
114	Procedure Modifier Code 1	1097	1098	2	Character	The 2-character code of the first procedure code modifier on the professional claim		
115	Procedure Modifier Code 2	1099	1100	2	Character	The 2-character code of the second procedure code modifier on the professional claim		
116	Procedure Modifier Code 3	1101	1102	2	Character	The 2-character code of the third procedure code modifier on the professional claim		
117	Procedure Modifier Code 4	1103	1104	2	Character	The 2-character code of the fourth procedure code modifier on the professional claim		
118	Revenue Code UB	1105	1108	4	Character	The CMS standard revenue code from the facility claim		This field must be at the service/detail level.
119	Third Party Amount	1109	1118	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
120	Units of Service	1119	1122	4	Numeric	Client-specific quantity of services or units		
121	Funding Type Code	1123	1123	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		Blank Fill this field at this time.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
122	Account Structure	1124	1143	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
123	HRA Amount	1144	1153	10	Numeric	The amount paid from the HRA as a result of this claim.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
124	HSA Amount	1154	1163	10	Numeric	The amount paid from the HSA as a result of this claim.		Only send if applicable to the plan type and if available.
125	Present on Admission Principal	1164	1164	1	Character	The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission. Standard Values: 1 – Unreported/Not Used N – No, not present at admission U – Unknown W – Clinically Undetermined Y – Yes, present at admission	See Notes	If standard values are not used, define in the **Data Dictionary.**
126	Present on Admission 02	1165	1165	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
127	Present on Admission 03	1166	1166	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
128	Present on Admission 04	1167	1167	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
129	Present on Admission 05	1168	1168	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
130	Present on Admission 06	1169	1169	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
131	Present on Admission 07	1170	1170	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
132	Present on Admission 08	1171	1171	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
133	Present on Admission 09	1172	1172	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
134	Present on Admission 10	1173	1173	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
135	Present on Admission 11	1174	1174	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
136	Present on Admission 12	1175	1175	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
137	Present on Admission 13	1176	1176	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
138	Present on Admission 14	1177	1177	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
139	Present on Admission 15	1178	1178	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
140	Present on Admission 16	1179	1179	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
141	Present on Admission 17	1180	1180	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
142	Present on Admission 18	1181	1181	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
143	Present on Admission 19	1182	1182	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
144	Present on Admission 20	1183	1183	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
145	Present on Admission 21	1184	1184	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
146	Present on Admission 22	1185	1185	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
147	Present on Admission 23	1186	1186	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
148	Present on Admission 24	1187	1187	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
149	Present on Admission 25	1188	1188	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the **Data Dictionary.**
150	DRG MS Payment Code	1189	1191	3	Character	The Diagnosis Related Group (MS-DRG) code under which the claim was paid.		
151	ICD Version	1192	1192	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim.	See Notes	If 0 and 9 not used, values defined in the **Data Dictionary.**
152	Tax Amount	1193	1202	10	Numeric	The amount charged by some states per medical claim.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
153	Tax Type Code	1203	1203	1	Character	Data Supplier specific code identifying the state and/or type of tax.	Yes	Blank Fill this field at this time
154	NDC Number Code	1204	1214	11	Character	The FDA (Food and Drug Administration) registered number for the drug. Please include for any drugs dispensed in the medical setting if available.		Please leave out the dashes.
155	Penalty Amount	1215	1224	10	Numeric	Penalty amount on the claim		
156	Referral Indicator	1225	1225	1	Character	Indicates if patient was referred		
157	Non-Medicare Paid Amount	1226	1235	10	Numeric	Third party amount, non-Medicare		
158	Withhold Amount	1236	1245	10	Numeric	Amount withheld		
159	Filler	1246	1699	454	Character	Reserved for future use		Fill with blanks
160	Record Type	1700	1700	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Medical Functional Specifications for File Layout

--- Trailer Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1699	1655	Character	Reserved for future use	Fill with Blanks
6	Record Type	1700	1700	1	Character	Record Type Identifier	Hard Code 'T'

TRUVEN HEALTH ANALYTICS

Covered California EAS
Drug Claims Functional Specification
3/15/2016

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
3/16/2016	Dan Lopez	Added new field for Pharamcy Name due to data quality reviews
6/12/2015	Dan Lopez	Updated following all data summits
6/9/2015	Katie Andrada-Bacorn	Updated following initial data summit
5/20/2015	Katie Andrada-Bacorn	Added fields to the Detail Layout

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a prescription drug claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Truven Health Analytics via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

DEFINITIONS AND DENIED CLAIMS

Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.

If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

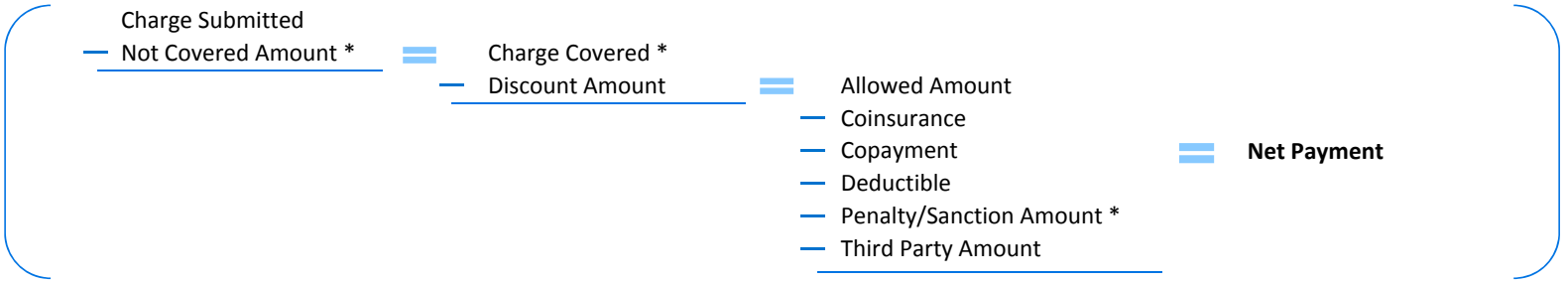
Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:

- **Fully denied claim** : The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- **Partially denied claim :** The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

FINANCIAL RELATIONSHIP

Truven Health defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Truven Health defines these as follows:

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

A financial **adjustment** is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well. The original and adjustment need not appear in the same file.

After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
1	Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		Blank Fill this field at this time.
2	CC Subscriber ID	10	29	20	Character	Unique code assigned by CC to the subscriber		
3	Enrollee/member SSN	30	38	9	Character	Member's Social Security Number		Blank Fill this field at this time.
4	CC_MemberID	39	58	20	Character	The member ID as assigned by Covered California		
5	Plan_MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Blank Fill this field at this time.
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Blank Fill this field at this time.
7	Claim ID	99	148	50	Character	The client-specific identifier of the claim.		
8	Date of Birth	149	158	10	Date	The birth date of the person.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
9	Gender Code	159	159	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
10	Adjustment Type Code	160	160	1	Character	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the **Data Dictionary.**
11	Allowed Amount	161	170	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 - digit, implied decimal)
12	Charge Submitted	171	180	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 - digit, implied decimal)
13	Claim Type Code	181	183	3	Character	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the **Data Dictionary.**
14	Coinsurance	184	193	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
15	Copayment	194	203	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
16	Date of Service	204	213	10	Date	The date of service for the drug claim.		MM/DD/CCYY format
17	Date Paid	214	223	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
18	Days Supply	224	227	4	Numeric	The number of days of drug therapy covered by the prescription.		
19	Deductible	228	237	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 - digit, implied decimal)
20	Dispensing Fee	238	247	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.		Format 9(8)v99 (2 - digit, implied decimal)
21	Formulary Indicator	248	248	1	Character	An indicator that the prescription drug is included in the formulary.		"Y" or "N"
22	Ingredient Cost	249	258	10	Numeric	The charge or cost associated with the pharmaceutical product.		Format 9(8)v99 (2 - digit, implied decimal)
23	Metric Quantity Dispensed	259	269	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.		Format 9(8)v99 (3 - digit, implied decimal)

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
24	NDC Number Code	270	280	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.		Please leave out the dashes.
25	Net Payment	281	290	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
26	Network Paid Indicator	291	291	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.		"Y" or "N"
27	Network Provider Indicator	292	292	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.		"Y" or "N"
28	PCP Responsibility Indicator	293	293	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
29	Pharmacy NPI Number	294	303	10	Character	The National Provider Identifier for the pharmacy.		
30	Pharmacy Provider ID	304	316	13	Character	The identifier for the provider of service.		This should be the NCPDP (National Council for Prescription Drug Programs) number. (Note: The pharmacy NPI is collected in field #28 in this layout.)
31	Pharmacy Name	317	356	40	Character	The name of the pharmacy where the prescription was filled.		3/15/16 - Added this field to the layout
32	Pharmacy Address 1	357	406	50	Character	The first line of the address for the pharmacy.		
33	Pharmacy Address 2	407	436	30	Character	The second line of the address for the pharmacy.		
34	Pharmacy County	437	441	5	Character	The FIPS state/county code for the pharmacy.		
35	Pharmacy City	442	471	30	Character	The city for which the pharmacy resides.		
36	Pharmacy State	472	473	2	Character	The state in which the pharmacy resides.		
37	Pharmacy Zip	474	478	5	Character	The zip code of the pharmacy		
38	Pharmacy Zip Plus 4 Code	479	482	4	Character	The zip plus 4 code of the pharmacy		
39	Referring Provider ID	483	495	13	Character	The ID number of the provider who prescribed the drug.		
40	Referring Provider First name	496	525	30	Character	The First Name of the provider who referred the patient or ordered the test or procedure.		
41	Referring Provider Last Name	526	555	30	Character	The Last Name of the provider who referred the patient or ordered the test or procedure.		
42	Referring Provider Middle Initial	556	556	1	Character	The Middle Initial of the provider who referred the patient or ordered the test or procedure.		
43	Referring Provider Address 1	557	606	50	Character	The first line of the Referring provider's address		
44	Referring Provider Address 2	607	636	30	Character	The second line of the Referring provider's address		
45	Referring Provider City	637	666	30	Character	The Referring provider's city		
46	Referring Provider State	667	668	2	Character	The Referring provider's state		

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
47	Referring Provider Zip Code	669	673	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
48	Referring Provider Zip Plus 4 Code	674	677	4	Character	The zip plus 4 code of the Referring Provider		
49	Referring Provider NPI	678	687	10	Character	Referring Provider Submitted National Provider Identifier Type 1		
50	Referring Provider DEA number	688	699	12	Character	The DEA Number of the referring provider		
51	Referring Provider TIN	700	708	9	Character	The Tax ID of the referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for Medical Groups and Facilities are necessary.		For doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is poplulated on that record. However, TINs on facility claims must be provided.
52	Rx Dispensed as Written Code	709	709	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.		
53	Rx Mail or Retail Code	710	710	1	Character	The Truven Health standard code indicating the purchase place of the prescription.		"M" for Mail, "R" for Retail
54	Rx Payment Tier	711	711	1	Character	Client-specific description for the payment tier of the drug claim.		Data Supplier will help Truven Health understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary 4. Specialty Drug
55	Rx Refill Number	712	715	4	Numeric	A number indicating the original prescription or the refill number.		This is the refill number, not the number of refills remaining.
56	Tax Amount	716	725	10	Numeric	The amount of sales tax applied to the cost of the prescription.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
57	Third Party Amount	726	735	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal)
58	Discount Amount	736	745	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 - digit, implied decimal)
59	Funding Type Code	746	746	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		Blank Fill this field at this time.
60	Account Structure	747	766	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Additional fields may be added to the layout if there is more than one component of the account structure.
61	HRA Amount	767	776	10	Numeric	The amount paid from the HRA to pay the provider.		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
62	HSA Amount	777	786	10	Numeric	The financial amount of the healthcare savings account for consumer-driven health plans		Provide only if applicable to the play type and if available

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields								
63	Compound Code	787	787	1	Character	Client-specific code for the compound of the drug.	Yes	Compound Codes will be identified in the **Data Dictionary.** Note that the NCPDP values include: '0' – Not Specified '1' – Not a Compound '2' – Compound
64	Excess Copayment Amount	788	797	10	Numeric	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.		Format 9(8)v99 (2 - digit, implied decimal)
65	Capitation Indicator	798	798	1	Character	Service is/is not capitated (Y/N)		Blank Fill this field at this time.
66	NABP Number	799	808	10	Character	National Association of Boards of Pharmacy Number		
67	MAC Price	809	818	10	Numeric	The maximum acquisition cost price		Not required at this time. Set all values to 000 to accommodate the 2-digit implied decimal.
68	Penalty Amount	819	828	10	Numeric	The penalty amount on the claim		
69	Withhold Amount	829	838	10	Numeric	The amount withheld		
70	Filler	839	1199	361	Character	Reserved for future use		Fill with blanks
71	Record Type	1200	1200	1	Character	Record type identifier		Hard Code to "D"

Drug Claims Functional Specifications for File Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Truven Health Analytics Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1199	1155	Character	Reserved for future use	Fill with Blanks
6	Record Type	1200	1200	1	Character	Record Type Identifier	Hard Code 'T'

Appendix 2 to Attachment 7

Appendix 2 to Attachment 7: Measurement Specifications

QHP Issuers shall use the following metrics to establish baseline measurements for Attachment 7 requirements and demonstrate improvement on each of these measurements over time. These metrics were reported in the 2017 Application for Certification or in subsequent data requests and must be reported according to the table below. Additionally, QHP Issuers must report these metrics as necessary upon Covered California's request. Covered California and QHP Issuers shall work collaboratively during the term of this Agreement to enhance these specifications to further define the requirements. Hospitalization metrics for disparities measurement are to be reported as both separately-reported standard Prevention Quality Indicator (PQI) (ambulatory sensitive admissions) measures and the composite metric of combined PQI, which is not a national standard. Covered California will assess these two approaches during the baseline measurement years (2015 and 2016) and anticipates a smaller set of measures for measurement year 2017.

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
1	3.01	Self-Reported Racial or Ethnic Identity	Report members self-identifying racial and ethnic group through the enrollment application, web site registration, health assessment, reported at provider site, etc.	Covered California members enrolled during the applicable Plan Year who self-identified a racial or ethnic group.	Total Covered California membership for the applicable Plan Year. Exclude members actively selecting an option to decline self-report (e.g. "decline to state" or "prefer not to say").	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Applications for Certification - QIS	• California SB 853: The Health Care Language Assistance Act
2	3.01	Racial or Ethnic Identity	Report racial and ethnic identity based on self-report or proxy methodology (i.e. zip code or surname analysis, or both)	Covered California members enrolled during the applicable Plan Year with racial and ethnic group identified	Total Covered California membership for the applicable Plan Year	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	• California SB 853: The Health Care Language Assistance Act
3	3.01	Diabetes Care: HbA1c Control < 8.0% (NQF 0575)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino	HEDIS numerator administrative specifications for HbA1c Control <8.0%	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • Medi-Cal External Accountability Set • IHA P4P • Quality Rating System

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino							
4	3.01	CBP – Controlling High Blood Pressure (NQF 0018)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Controlling High Blood Pressure	HEDIS eligible population specifications for Controlling High Blood Pressure	Clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • Medi-Cal External Accountability Set • IHA P4P • Quality Rating System
5	3.01	Asthma Medication Ratio Ages 5-85 (NQF 1800)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Asthma Medication Ratio	HEDIS eligible population specifications for Asthma Medication Ratio	Administrative data	Annually	January 1 – December 31 of applicable measurement year and prior measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • IHA P4P
6	3.01	Antidepressant Medication Management (NQF 0105)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander ▪ White, not Hispanic or Latino	HEDIS numerator specifications for Antidepressant Medication Management	HEDIS eligible population specifications for Antidepressant Medication Management	Pharmacy data	Annually	May 1 of prior measurement year – April 30 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NCQA • IHA P4P
7	3.01	Depression Response at Twelve Months-Progress Towards Remission (NQF 1885)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or Other Pacific Islander	MN Community Measurement specifications for numerator	MN Community Measurement specifications for denominator	Clinical data	Annually	January 1 – December 31 of applicable measurement year	Deferred until further notice	• CMS Consensus Core Set: ACO and PCMH Primary Care Measures

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			▪ White, not Hispanic or Latino							
8	3.01	Diabetes Hospitalization Measure	Combine the following AHRQ PQI measures for the Diabetes Hospitalization Measure: • PQI #1 – Diabetes Short-Term Complications Admissions Rate • PQI #3 – Diabetes Long-Term Complications Admissions Rate • PQI #14 - Uncontrolled Diabetes Admission Rate • PQI #16 – Lower-Extremity Amputation among Patients with Diabetes Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	Combine AHRQ measure numerator specifications for PQI #1, 3, 14, 16	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
9	3.01	Admissions for diabetes short-term complications, based on PQI #1 – Diabetes Short-Term Complications Admissions Rate (NQF 0272)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #1 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set • NQF Population Health Measures
10	3.01	Admissions for diabetes long-term complications, based on PQI #3 – Diabetes Long-Term Complications	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American	AHRQ PQI #3 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
		Admissions Rate (NQF 0274)	▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino							
11	3.01	Admissions for uncontrolled diabetes, based on PQI #14 – Uncontrolled Diabetes Admission Rate (NQF 0638)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #14 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures
12	3.01	Admissions for lower-extremity amputation, based on PQI #16 - Lower-Extremity Amputation among Patients with Diabetes Rate (NQF 0285)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #16 numerator specifications	HEDIS eligible population specifications for Comprehensive Diabetes Care (NQF 0731)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• NQF Population Health Measures
13	3.01	Hypertension Hospitalization Measure	Combine the following AHRQ PQI measures for the Hypertension Hospitalization Measure: • PQI #7 – Hypertension Admission Rate • PQI #8 – Heart Failure Admission Rate • PQI #13 – Angina Without Procedure Admission Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	Combine AHRQ measure numerator specifications for PQI #7, 8, 13	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
14	3.01	Admissions for hypertension, based on PQI #7 - Hypertension Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #7 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
15	3.01	Admissions for heart failure, based on PQI #8 – Heart Failure Admission Rate (NQF 0277)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #8 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set • Accountable Care Organization Quality Measures (Shared Savings Program)
16	3.01	Admissions for angina, based on PQI #13 – Angina Without Procedure Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #13 numerator specifications	HEDIS eligible population specifications for Controlling High Blood Pressure	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
17	3.01	Asthma Hospitalization Measure	Combine the following AHRQ PQI measures for the Asthma Hospitalization Measure: • PQI #5 COPD or Asthma in Older Adults Admission Rate • PQI #11: Bacterial Pneumonia Admission Rate • PQI #15: Asthma in Younger Adults Admission Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories:	Combine AHRQ measure numerator specifications for PQI #5, 11, 15. Exclude COPD codes from PQI #5.	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
			• Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino							
18	3.01	Admissions for asthma in older adults, based on PQI #5 - COPD or Asthma in Older Adults Admission Rate (NQF 0275)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #5 numerator specifications. Exclude COPD codes.	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set
19	3.01	Admissions for bacterial pneumonia, based on PQI #11 - Bacterial Pneumonia Admission Rate (NQF 0279)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #11 numerator specifications	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017 (optional), 2018, and 2019 Application for Certification - QIS	
20	3.01	Admissions for asthma in younger adults, based on PQI #15 - Asthma in Younger Adults Admission Rate	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ American Indian or Alaska Native ▪ Asian ▪ Black or African American ▪ Hispanic or Latino ▪ Native Hawaiian or other Pacific Islander ▪ White, not Hispanic or Latino	AHRQ PQI #15 numerator specifications	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• Medicaid 2016 Adult Core Set
21	4.01	Primary Care Physician Selection	Report members by product in the health plan's Covered California business with a personal care physician (PCP)	Number of Covered California members	Total Covered California membership enrolled during	Administrative data	Quarterly	January 1 – December 31 (quarterly reporting	2017, 2018, and 2019 Application for Certification -	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
				enrolled during the applicable Plan Year who have selected or were assigned to a PCP	the applicable Plan Year			periods to be defined upon request by Covered California)	QIS / quarterly reports as requested	
22	4.02	Primary Care Payment Strategies	Report the number and percentage of California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of California members enrolled during the applicable Plan Year attributed to a provider with a payment reform strategy	Total California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS	
23	4.02	Primary Care Payment Strategies	Report the number and percentage of Covered California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of Covered California members enrolled during the applicable Plan Year attributed to a provider with a payment reform strategy	Total Covered California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS	
24	4.03	Membership Attributed to IHMs	Report the number and percentage of California members in each product who are managed under an IHM	Number of California members enrolled during the applicable Plan Year managed under an IHM	Total California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
25	4.03	Membership Attributed to IHMs	Report the number and percentage of Covered California members in each product who are managed under an IHM	Number of Covered California members enrolled during the applicable Plan Year managed under an IHM	Total Covered California membership enrolled during the applicable Plan Year	Administrative / financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
26	5.03	Hospitals reporting to CMQCC	Report hospital participation in CMQCC	Number of network hospitals reporting to CMQCC	Total number of hospitals providing maternity services in network	Network data/CMQCC participant list	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	• CalSIM
27	5.03	Hospitals meeting CalSIM goal for C-sections	Report hospital network performance for meeting CalSIM NTSV C-Section goal	Number of hospitals meeting CalSIM goal of NTSV C-Section rate at or below 23.9 percent	Total number of hospitals providing maternity services in network	Network data/clinical data submitted to CMQCC	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CalSIM • Healthy People 2020 NTSV target of 23.9%
28	5.03	NTSV C-Section rate for each network hospital	For the plan's network of hospitals providing maternity services, report each hospital name, location, product network (HMO, PPO, EPO), and NTSV C-Section rate	Total number of NTSV C-Section deliveries	Total number of NTSV deliveries	Network data/clinical data submitted to CMQCC	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CalSIM • Healthy People 2020 NTSV target of 23.9%
29	5.01	Payment strategies for maternity services	Report number of hospitals paid under each type of payment strategy for maternity services and the denominator (total number of network hospitals)	Number of hospitals paid under payment strategy or each payment strategy	Total number of network hospitals providing maternity services	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
30	5.02	Opioid Adverse Events (Patients	Report rate for each network hospital:	Number of inpatients treated with an	Number of inpatients who received an	Clinical data (medical record review,	Annually	January 1 – December 31 of applicable	2018 and 2019 Application for	• CMS Hospital Improvement

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
		Treated with Naloxone)	Opioid-related ADE caused by medical error and/or adverse drug reactions Rate Calculation: (Numerator / Denominator) x 100 Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data)	opioid who received naloxone	opioid (top 5-10 prescribed)	incident reporting systems, pharmacy reporting system) reported to CMS; HQI proposed		measurement year	Certification - QIS	Innovation Networks (HIINs)
31	5.02	CAUTI SIR for all hospitals	Report SIR for each network hospital excluding small-denominator hospitals:: CAUTI Standardized Infection Ration (SIR) – All Tracked Units – Relative performance Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline	Number of observed inpatient healthcare-associated CAUTIs for all tracked units	Number of predicted inpatient healthcare-associated CAUTIs for all tracked units (determined by NHSN)	CMS Hospital Quality Compare[1]	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)
32	5.02	Urinary Catheter Utilization Ratio	Report rate for each network hospital: Urinary Catheter Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) x 100 Lower ratios are generally associated with better performance and may also impact the CAUTI rate	Number of inpatient indwelling urinary catheter days for all tracked units	Number of inpatient bed days for all tracked units	Numerator may be obtained from NHSN or Partnership for Patients data reported to CMS. Denominator may be obtained from OSHPD, CDPH, or other public source.	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)

[1] Datasets containing the CAUTI SIR for all California hospitals from 2005 through 2015 are available here: https://data.medicare.gov/data/archives/hospital-compare

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
33	5.02	CLABSI SIR	Report SIR for each network hospital: CLABSI SIR – All Tracked Units Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient CLABSIs for all tracked units	Number of expected inpatient CLABSIs for all tracked units (determined by NHSN)	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
34	5.02	Central Line Utilization Ratio	Report rate for each network hospital: Central Line Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) × 100 Lower ratios are generally associated with better performance and may also impact the CLABSI rate	Number of inpatient central line days for all tracked units	Number of inpatient bed days for all tracked units	Numerator may be obtained from NHSN, CDPH, or Partnership for Patients data reported to CMS. Denominator may be obtained from OSHPD, CDPH, or other public source.	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS)
35	5.02	*Clostridium difficile* SIR	Report SIR for each network hospital: Lab-Identified C. Difficile SIR Rate Calculation: Numerator / Denominator Target Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient hospital-onset C. difficile lab identified events for all tracked units	Number of expected inpatient hospital-onset cases of C. difficile for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
								year and the previous year.	contracting data.	
36	5.02	SSI-Colon SIR	Report SIR for each network hospital:: Colon Surgery SSI SIR Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed SSIs for colon surgeries (based on NHSN definition)	Number of predicted SSIs for colon surgeries (determined by NHSN definition)	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
37	5.02	MRSA BSI SIR	Report SIR for each network hospital: MRSA BSI SIR Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed MRSA BSI cases	Number of predicted MRSA BSI cases	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year. For hospitals with predicted infections of less than 0.2, report the combined, 2-year SIR for the measurement year and the previous year.	2017, 2018, and 2019 Application for Certification - QIS. Covered California will distribute data to contracted health plans for analysis and incorporation with network contracting data.	• CMS Hospital Engagement Networks (HENS) • CDPH – HAI Annual Report
38	5.01	Hospital Reimbursement at Risk for Quality Performance	Report the percentage of hospital performance at risk for quality performance (metrics may include but are not limited to HACs, readmissions, patient satisfaction, etc.)	Hospital payment dollars tied to quality performance	Total hospital payment dollars	Financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	
39	5.01	Hospitals with Reimbursement at Risk for Quality Performance	Report the number and percentage of hospitals with reimbursement at risk for quality performance (metrics may include but are not limited to HACs, readmission, patient satisfaction, etc.)	Hospitals with payment tied to quality performance	Total number of network hospitals	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS	

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Measurement Period	Reporting Method	Alignment with Federal/State Programs, Laws, and/or other quality organizations
40	6.01	Members Using Wellness Benefit	Report the number and percentage of members who have a preventive care visit ($0 member cost share)	Members incurring at least one preventive care visit/service	Total membership across all lines of membership excluding Medicare	Claim/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification	
41	6.01	Members identified as obese who are participating in a weight management program	Report the number of obese members who are participating in weight management programs	Number of California members identified as obese who are participating in weight management program	California members identified as obese	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	
42	6.01	Members identified as tobacco dependent who are participating in a smoking cessation program	Report the number of tobacco-dependent members who are participating in smoking cessation programs	California members identified as tobacco dependent participating in smoking cessation program	California members identified as tobacco dependent	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI	