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 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.

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
1	3.01~~(a)(i)~~	Self-Reported Racial and Ethnic Identity	Report members self-identifying racial and ethnic group through the enrollment application, web site registration, health assessment, reported at provider site, etc.	Members enrolled during the applicable Plan Year -self-identifying racial and ethnic group	Total membership (all lines of business excluding Medicare) for the applicable Plan Year	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Applications for Certification - QIS
2	3.01~~(a)(ii)~~	Racial and Ethnic Identity	Report racial and ethnic identity based on self-report or proxy methodology (i.e. zip code or surname analysis, or both)	Members enrolled during the applicable Plan Year with racial and ethnic group identified	Total membership (all lines of business excluding Medicare) 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
3	3.01~~(b)(i)~~	~~IHA #7 –~~ Diabetes Care: HbA1c Control < 8.0%	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	~~Refer to IHA MY 2016 P4P Clinical Specifications: Diabetes Care~~ Refer to HEDIS specifications for measure description and eligible population	~~Refer to IHA MY 2016 P4P Clinical Specifications: Diabetes Care~~ Refer to HEDIS specifications for measure description and eligible population	~~Claim/ encounter or automated laboratory~~Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
4	3.01~~(b)(i)~~	CBP – Controlling High Blood Pressure	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	Refer to HEDIS specifications for measure description and eligible population	Refer to HEDIS specifications for measure description and eligible population	~~Claim/ encounter~~Clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
5	3.01~~(b)(i)~~	~~IHA #28 –~~ Asthma Medication Ratio Ages 5-85	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino	~~Refer to IHA MY 2016 P4P Clinical Specifications: Asthma~~	~~Refer to IHA MY 2016 P4P Clinical Specifications: Asthma~~	~~Claim/ encounter and pharmacy~~Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year and prior	2017, 2018, and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
			• White, not Hispanic or Latino • Unknown	~~Medication Ratio~~ Refer to HEDIS specifications for measure description and eligible population	~~Medication Ratio~~ Refer to HEDIS specifications for measure description and eligible population			measurement year	
6	3.01~~(b)(i)~~	~~AMM – Antidepressant Medication Management~~ Depression Response at Twelve Months- Progress Towards Remission – NQF # 1885	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	Refer to ~~HEDIS~~ MN Community Measurement specifications for measure description and eligible population	Refer to ~~HEDIS~~ MN Community Measurement specifications for measure description and eligible population	~~Claim/ encounter and pharmacy~~Clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
7	3.01~~(b)(i)~~	~~Hospital Admission Rate for Diabetes~~ Uncontrolled Diabetes Admission Rate (PQI 14) – NQF # 0638	Apply only to members with diabetes. Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	~~Hospital admissions for any reason excluding trauma among members with diabetes (use HEDIS eligible population definition for diabetes)~~Refer to AHRQ measure specifications for numerator description.	~~Members with diabetes (use HEDIS eligible population definition for diabetes)~~ Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for diabetes.	~~Claim/ encounter~~Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
8	3.01~~(b)(i)~~	ED ~~Admission~~ Visit Rate for Diabetes	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	ED ~~admissions~~ visits for any reason excluding trauma among members with diabetes (use HEDIS eligible population definition for diabetes)	Members with diabetes (use HEDIS eligible population definition for diabetes)	~~Claim/encounter~~ Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
9	3.01~~(b)(i)~~	Hospital Admission Rate for Hypertension	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander	Hospital admissions for any	Members identified as hypertensive	Administrative data	Annually		2017, 2018, and 2019 Application for

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
			• Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	cardiovascular diagnosis (heart failure, CAD, stroke)[1] or renal failure comorbid or due to hypertension	(use HEDIS eligible population definition)				Certification - QIS
10	3.01	ED Visit Rate for Hypertension	Apply only to members with hypertension. Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	ED admissions for any cardiovascular diagnosis (heart failure, CAD, stroke)[2] or renal failure comorbid or due to hypertension	Members identified as hypertensive (use HEDIS eligible population definition)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
11	3.01~~(b)(i)~~	~~Hospital Admission Rate for Asthma~~Asthma in Younger Adults Admission Rate (PQI 15) – NQF# 0283	Apply only to members with asthma. Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	~~Hospital admissions for pulmonary diagnoses among members with asthma (use HEDIS eligible population for asthma)~~Refer to AHRQ measure specifications for numerator description.	~~Members with asthma (use HEDIS eligible population for asthma)~~Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for asthma.	~~Claim/ encounter~~ Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
12	3.01~~(b)(i)~~	~~ED Admission Rate for Asthma~~Asthma Admission Rate (PDI 14) – NQF # 0728	Apply only to members with asthma. Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	~~ED admissions for pulmonary diagnoses among members with asthma (use HEDIS eligible population for asthma)~~ Refer to AHRQ measure specifications for numerator description.	~~Members with asthma (use HEDIS eligible population for asthma)~~ Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for asthma.	~~Claim/ encounter~~Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS

[1] List of applicable ICD-10 codes forthcoming for future stakeholder review and comment

[2] List of applicable ICD-10 codes forthcoming for future stakeholder review and comment

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
13	3.01	Bacterial Pneumonia Admission Rate (PQI 11) – NQF # 0279	Apply only to members with asthma. Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	Refer to AHRQ measure specifications for numerator description.	Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for asthma.	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
14	3.01	ED Visit Rate for Asthma	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	ED admissions for pulmonary diagnoses among members with asthma (use HEDIS eligible population for asthma)	Members with asthma (use HEDIS eligible population for asthma).	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
153	3.01(b)(i)	ED Admission Visit Rate for Depression	Report rates by race/ethnicity: • Asian/Native Hawaiian or other Pacific Islander • Black or African American • Hispanic or Latino • White, not Hispanic or Latino • Unknown	ED admissions among members with depression (use HEDIS eligible population for members with a diagnosis of major depression)	Members with a diagnosis of major depression (use HEDIS eligible population)	Claim/ encounterAdministrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
164	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 enrolled during the applicable Plan Year who have selected or were assigned to a PCP	Total Covered California membership enrolled during the applicable Plan Year	Administrative data	Quarterly	January 1 – December 31 (quarterly reporting periods to be defined upon request by Covered California)	2017, 2018, and 2019 Application for Certification - QIS / quarterly reports as requested
175	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	2017, 2018, and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
1~~8~~6	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	~~2017,~~ 2018~~,~~ and 2019 Application for Certification - QIS
19~~17~~	4.03	Membership Attributed to IHMs	~~Within QIS report for existing or planned integrated systems of care, r~~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
20~~18~~	4.03	Membership Attributed to IHMs	~~Within QIS report for existing or planned integrated systems of care, r~~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
21~~19~~	5.~~01~~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
22~~20~~	5.~~01~~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
23~~21~~	5.~~01~~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

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
2422	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
23	5.02	Excessive Anticoagulation among Inpatients Receiving Warfarin (INR >5.0)	Report rate for each network hospital: Anticoagulation-associated adverse drug event (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)	All inpatients experiencing excessive (INR > 5.0) anticoagulation with warfarin after 24 hours of admission	Inpatients receiving warfarin anticoagulation therapy	Clinical data (medical record review, incident reporting systems, laboratory reporting systems) reported to CMS	Annually		2017, 2018, and 2019 Application for Certification - QIS
24	5.02	Hypoglycemia in Inpatients Receiving Insulin (Blood Glucose ≤ 50.0)	Report rate for each network hospital: Diabetes-related ADE in the inpatient setting 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)	Hypoglycemia (<50.0) in inpatients receiving insulin or other hypoglycemic agents	Inpatients receiving insulin or other hypoglycemic agents	Clinical data (medical record review, incident reporting systems) reported to CMS	Annually		2017, 2018, and 2019 Application for Certification - QIS
25	5.02	Opioid Adverse Events (Patients Treated with Naloxone)	Report rate for each network hospital: 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)	Number of inpatients treated with an opioid who received naloxone	Number of inpatients who received an opioid (top 5-10 prescribed)	Clinical data (medical record review, incident reporting systems, pharmacy reporting system) reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
26	5.02	CAUTI Rate	Report rate for each network hospital: CAUTI Rate – All Tracked Units - to evaluate improvement	Number of inpatient healthcare-associated	Number of inpatient indwelling urinary catheter	National Healthcare Safety Network (NHSN) or	Annually	January 1 – December 31 of applicable	2017, 2018, and 2019 Application for

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
			Rate Calculation: (Numerator / Denominator) x 1,000 Target-Setting Approach: Twelve months historical data for baseline	CAUTIs for all tracked units	days for all tracked units	Partnership for Patients data reported to CMS		measurement year	Certification - QIS
27	5.02	CAUTI SIR	Report rate for each network hospital: 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)	NHSN or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
28	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	NHSN or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
29	5.02	CLABSI Rate	Report rate for each network hospital: CLABSI Rate – All Tracked Units Rate Calculation: (Numerator / Denominator) x 1,000 Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient healthcare-associated CLABSIs for all tracked units	Number of inpatient central line days for all tracked units	NHSN, California Department of Public Health (CDPH), or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
30	5.02	CLABSI SIR	Report rate 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	2017, 2018, and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
31	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	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
32	5.02	C. Diff Rate	Report rate for each network hospital: Lab-Identified C. Diff Rate Rate Calculation: (Numerator / Denominator) × 1,000 Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of inpatient hospital-onset C. diff lab identified events for all tracked units	Number of inpatient bed days for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
33	5.02	C. Diff SIR	Report rate for each network hospital: Lab-Identified C. Diff 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. diff lab identified events for all tracked units	Number of expected inpatient hospital-onset cases of C. diff for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
34	5.02	SSI-Colon Rate	Report rate for each network hospital: Colon Surgery SSI Rate Rate Calculation: (Numerator / Denominator) × 100 Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of SSIs related to colon surgeries (based on NHSN definition)	Inpatients having the colon procedures included in the NHSN operative procedure category	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
35	5.02	SSI-Colon SIR	Report rate for each network hospital: Colon Surgery SSI SIR	Number of observed SSIs for colon surgeries (based	Number of predicted SSIs for colon surgeries	NHSN, CDPH, or Partnership for Patients	Annually	January 1 – December 31 of applicable	2017, 2018, and 2019 Application for

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	Reporting Period	Reporting Method
			Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	on NHSN definition)	(determined by NHSN definition)	data reported to CMS		measurement year	Certification - QIS
36	5.~~03~~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
37	5.~~03~~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
38	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
39	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
40	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