August 18, 2014

ADVANCE NOTICE OF RE-ADOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give advance notice at least five working days of their intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file a re-adoption of an Emergency Rulemaking package with the Office of Administrative Law (OAL) that establishes the process for eligible health issuers in the Individual and SHOP exchanges to submit proposed qualified health plans (QHP) for recertification and for eligible health issuers to submit proposed QHPs as new market entrants. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received by both the Exchange and the Office of Administrative Law within five calendar days of the Exchange's filing at OAL. Response to these comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Andrea Rosen
1601 Exposition Blvd.
Sacramento, CA 95815

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

BOARD MEMBERS Diana S. Dooley, Chair Kimberly Belshé Paul Fearer Susan Kennedy Robert Ross, MD EXEC DIRECTOR Peter V. Lee

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for one hundred eighty days (180) days. Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. There will be a 45-day comment period within the 180-day certification period following the effective date of the emergency regulations.

You may also view the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address: https://www.coveredca.com/hbex/regulations/.

If you have any questions concerning this Advance Notice, please contact Andrea Rosen at (916) 228-8343.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds an emergency exists and that this proposed emergency regulation is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare.

This emergency rulemaking was previously adopted by OAL on March 6, 2014 and will expire on September 2, 2014. The Exchange now seeks a re-adoption. The Exchange is in the process of making this rulemaking permanent and has proceeded with diligence to comply with the requirements in Government Code § 11346.1(e), and has made substantial progress in that regard. For example, the Exchange has been revising and finalizing regulation text based on stakeholder comments and feedback, which will be addressed in the Initial Statement of Reasons, which is currently in progress. The California Health Benefit Exchange finance department is analyzing the economic impact on the regulations to complete the From 399 to publish the rulemaking to begin the permanent rulemaking process. We anticipate that the Initial Statement of Reasons and other necessary documents will be finalized and filed with OAL for publishing in the next several weeks.

This Finding of Emergency hereby incorporates by reference all documents in the original rulemaking file, which is file number 2014-0227-05E.

DEEMED EMERGENCY

The Exchange may “Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare” (Gov. Code § 100504(a)(6)).

AUTHORITY AND REFERENCE

Authority: Government Code Sections 100504 and 100505
Reference: Government Code Sections 100502, 100503, 100504 and 100505

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

The California Health Benefit Exchange Qualified Health Plan Issuer 2015 Renewal Application will be incorporated by reference in the proposed regulations.

The California Health Benefit Exchange Qualified Health Plan New Entrant Application for 2015 Plan Year will be incorporated by reference in the proposed regulations.

Summary of Existing Laws

Under the federal Patient Protection and Affordable Care Act (PPACA), each state is required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. (Gov. Code § 100500 et seq.) The Exchange is required to implement procedures for the certification and recertification of health plans as qualified health plans in both the Individual Exchange and the Small Business Health Options Program (SHOP). (Gov. Code § 100502(a) and Gov. Code § 100502(m)).

The proposed regulations will establish the Exchange's recertification and new entrant policies and procedures for the Individual Exchange and the SHOP. The proposed regulations will provide the health insurance issuers with a clear understanding of the processes required for recertification and new entry into the Individual Exchange and/or SHOP Exchange. The proposed regulations also define which health plans are eligible to apply as new market entrants.

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations.

JUSTIFICATION FOR DUPLICATION

These proposed regulations were developed with significant stakeholder engagement to implement the process for QHP and dental plan recertification and new entry in the Individual Exchange and the SHOP Exchange. While these regulations duplicate some federal regulations regarding recertification and new entry, this duplication is necessary to establish a complete and robust recertification and new entrant application process for the Individual Exchange and SHOP Exchange in California.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

None

LOCAL MANDATE

The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES (Attached Form 399)

This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Section 7 (commencing with Section

17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

COSTS OR SAVINGS TO STATE AGENCIES AND TO FEDERAL FUNDING (Attached Form 399)

The proposal results in additional costs to the California Health Benefit Exchange, which is currently funded by federal grant money and will become financially self-sufficient in 2015. The proposal does not result in any costs or savings to any other state agency.

Title 10, California Code of Regulations

Adopt Section 6420 to read:

Section 6420: QUALIFIED HEALTH PLAN (QHP) ISSUER 2015 RENEWAL APPLICATION

The purpose of this section is to set forth the requirements for eligible applicants to request recertification as a QHP for the Plan Year 2015 for the individual Exchange and for the SHOP Exchange. Applicants must complete the QHP Issuer 2015 Renewal Application in order to be recertified to offer, market and sell its QHPs in 2015. If an applicant meets the requirements for recertification, that issuer will be certified to offer, market and sell certified QHPs through Covered California for the Plan Year 2015. If an applicant fails to meet the requirements for recertification as a QHP for 2015, Covered California will decertify some or all of the applicant's plans for 2015.

(a) The definitions in Section 6410 of Article 2 of this chapter shall govern this section. Any other applicable terms not defined in Section 6410 are defined in subdivision (e).

(b) Applicants eligible to complete the QHP Issuer 2015 Renewal Application to be recertified to participate in the Individual Exchange in 2015 are limited to the entities listed below:

1) Blue Cross of California dba Anthem Blue Cross
2) California Physicians' Service dba Blue Shield of California
3) Chinese Community Health Plan, Inc.
4) Contra Costa County Medical Services dba Contra Costa Health Plan
5) Health Net Life insurance Company and Health Net of California, Inc.
6) Kaiser Foundation Health Plan, Inc.
7) L.A. Care Health Plan Joint Powers Authority
8) Molina Healthcare of California
9) Sharp Health Plan
10) County of Santa Clara dba Valley Health Plan
11) Western Health Advantage
12) Alameda Alliance Joint Powers Authority dba Alameda Alliance for Health
13) Ventura County dba Ventura County Health Care Plan

(c) Applicants eligible to complete the QHP Issuer 2015 Renewal Application in subsection (e) to be recertified to participate in the SHOP Exchange are limited to the entities listed below:

1) California Physicians' Service dba Blue Shield of California
2) Chinese Community Health Plan, Inc.
3) Health Net Life Insurance Company

4) Kaiser Foundation Health Plan, Inc.
5) Sharp Health Plan
6) Western Health Advantage

(d) Submission Requirements. Entities eligible to apply to be recertified to participate in the Individual Exchange or in the SHOP Exchange must comply with the submission date and requirements in (d)(2) if the events in subdivision (d)(3) do not occur.

(1) Submit a notice to Covered California indicating the applicant's intent to request recertification no later than 5:00 pm Pacific Time on March 17, 2014.
(2) Complete the application in subdivision (e) and submit to Covered California in its entirety no later than 5:00 pm Pacific Time on May 1, 2014.
(3) If the California Legislature amends Health and Safety Code Section 1399.849(c)(1) and Insurance Code § 10965.3 to set the start of open enrollment for the 2015 plan year as November 15, 2014 or any another date, applicants are required to complete the application in subdivision (e) and submit to Covered California in its entirety on or before 5:00pm Pacific Time on June 2, 2014.

(e) Qualified Health Plan (QHP) Issuer 2015 Renewal Application: Applicants who are eligible to complete the QHP Issuer 2015 Renewal Application for participation in the Individual Exchange or in the SHOP Exchange must complete the following QHP Issuer 2015 Renewal Application.

QHP Issuer 2015 Renewal Application

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

Issuer Name	
NAIC Company Code	
NAIC Group Code	
Regulator(s)	
Federal Employer ID	
HIOS/Issuer ID	
Corporate Office Address	
City	
State	
ZIP	
Primary Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	
Check all applicable categories: ☐Individual Commercial; ☐SHOP	

On behalf of the QHP issuer stated above, I hereby attest that I meet the requirements in this Renewal Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations and the information provided in response to this application and decertify Issuer's Qualified Health Plans offered on the Exchange should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the QHP issuer stated above to the terms of this Renewal Application.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
I. Licensed and in Good Standing						
1.1	Confirm that QHP issuer possesses and maintains its license to offer health insurance and is in good standing with applicable state, and federal authorities. (See Appendix A – Definition of Good Standing)	45 CFR §156.200(b)(4)			☐Yes ☐No	
1.2	Are you seeking any material modification of an existing license from the California Department of Managed Health Care for any commercial individual or small group products offered or proposed to be offered through Covered California? If yes, complete Attachment A (Regulatory Filings) to explain what modifications you are seeking and when those are anticipated to be approved?				☐Yes ☐No	
1.3	By submitting this application, QHP issuer agrees to negotiate a contract or contract amendment for 2015 in good faith with Covered California that will establish the terms and conditions of the business relationship.				☐Yes ☐No	
II. Provider Network Adequacy						
2.1	As a general requirement, QHP issuer must maintain continuing compliance with California provider network adequacy standards, laws & regulations established by the applicable regulatory agency. Applicant understands that provider network adequacy for its Covered California products will be determined by the applicable state regulatory agency and verified by Covered California. QHP issuer agrees to maintain a legally compliant provider network for each product offering (PPO,	45 CFR §156.230(a)(2)	Health and Safety Code §1300.67.2.1; 1300.67.2.2; 100,74.73 and Ins. Code§10133.65		☐Yes ☐No	

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	HMO, EPO) which includes sufficient number and types of providers to ensure that all services are accessible in a timely fashion to its Covered California enrollees. For Plan Year 2015, network adequacy standards applicable to dental provider networks will apply to the embedded pediatric dental benefit.					
2.2	QHP issuer agrees to maintain its provider network and continue to meets regulatory requirements based on QHP's 2015 Covered California projected and actual enrollment. Submit 2015 enrollment projections by product that QHP issuer intends to propose for 2015 by completing Attachment B (QHP 2015 Enrollment Projections).				☐Yes ☐No	
2.3	QHP products proposed for 2015 must cover the entire geographic service area for which the issuer is licensed in a rating region. Provide an updated geographic service area by product type for 2015 and include any changes from your 2014 service area by completing and uploading through SERFF[1] the most current Service Area Template located at: http://www.serff.com/plan_management_data_templates.htm and Attachment C1 - Plan Type by Rating Region (Individual), or if applicable, Attachment C2 – Plan Type by Rating Region (SHOP). Is Applicant making any changes to 2014 service area? If yes, describe briefly.				☐Yes ☐No	
III. Essential Community Provider (ECP) Network Requirements						
3.1	Describe how QHP issuer is continuing to meet or exceed Covered California's ECP network	45 CFR §156.230(a)(1) §156.235(a)				

[1] System for Electronic Rate and Form Filing; developed and owned by the National Association of Insurance Commissioners

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	requirements as defined in Appendix B (Essential Community Provider Network Requirements).					
3.2	If QHP asserts that it meets the ECP network requirement as defined in Appendix B through the alternate standard, explain the basis for this assertion and how the QHP issuer is continuing to meet the ECP network requirements under the alternate standard.	45 CFR §156.235(a)(2)				
IV. Quality and Delivery System Reform						
4.1	Describe QHP's process to ensure that QHP issuer can comply with QHP Contract Data Submission Requirements (as defined in Appendix C) to Covered California.					
4.2	QHP agrees to submit claims and encounter[2] data in the requested format to a third party vendor selected by Covered California for the purpose of performing clinical analytics.				☐Yes ☐No	
4.3	Confirm that QHP will submit eValue8™[3] modules found in Section 8.				☐Yes ☐No	
4.4	Specify accrediting organization (National Committee on Quality Assurance, Utilization Review Accreditation Commission, Accreditation Association for Ambulatory Health Care), accreditation status, next scheduled survey date(s), current accreditation status and proposed timeline if full accreditation has not been achieved or maintained.	45 CFR §1045; 45 CFR §156.275				
4.5	Confirm that QHP will submit, upon request, to the Exchange, Healthcare Effectiveness Data				☐Yes	

[2] Claims and encounter data reflect a health care visit by an enrollee to a provider of care or service.
[3] eValue8™ is a tool developed by the National Business Coalition on Health used by health care purchasers to compare health plans.

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
	Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to include the measure numerator, denominator, and rate for the required measures set that is reported to NCQA Quality Compass[4] or as applicable to DHCS, per each product type for which it collects data in California.				☐No	
V. Operational Readiness and Capacity						
5.1	QHP issuer confirms that it can and will accurately, appropriately and timely populate and submit SERFF templates at the request of Covered California for: (1) Rates (2) Service Area (3) Network (4) Benefit Plan Designs				☐Yes ☐No	
5.2	Demonstrate through existing QHP contract compliance or systems testing that QHP issuer operates systems which can accurately and timely report electronic data to Covered California using national standards for electronic transactions.					
5.3	Demonstrate, through submission of a March 2014 audit report or systems testing, as applicable, that QHP issuer can accept 834, 820 and other standard transaction electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize the information for its intended purpose (see Attachment D1 834 Enrollment File Error Listing & D2 834 Effectuation File Error Listing)					

[4] NCQA Quality Compass is a tool for comparing health plans based on quality improvement and other measures using a benchmark approach.

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
5.4	Provider directory data for both Individual and SHOP Exchange products must be included in this submission.	45 CFR §156.230(b)			☐Yes ☐No	
5.5	Describe how QHP issuer's computer systems can accurately and timely maintain an electronic interface with CalHEERS. Unless applicant can demonstrate this requirement through contract compliance, applicant must be available for testing data interfaces with the Exchange no later than July 1, 2014. QHP must maintain computer systems for testing any future modifications to the interface design and data interchange. Covered California requires QHPs to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.					
5.6	Describe the QHP issuer's systems ability to generate invoices for new members, which must be fully operational no later than October 15, 2014.					
5.7	Describe QHP issuer's systems which must accept premium payments from members no later than October 15, 2014 made using paper checks, cashier's checks, money orders, EFT and all general purpose pre-paid debit cards and credit cards. If such systems are not currently in place, describe plans to implement such systems, including any potential vendors, if applicable, and an implementation work plan with timeline. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.					

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
5.8	Describe how QHP issuer will comply with the federal requirement to serve the unbanked.	45 CFR 156.1240(a)(2)				
5.9	Describe how QHP issuer will maintain sufficient staffing in the customer service center to meet contractual performance goals.					
5.10	Describe QHP issuer's plans that are in place for the purpose of detecting and reporting incidents of fraud, waste and abuse. Provide a description of such plans and their efficacy.					
5.11	Describe any education efforts QHP issuer provides to members to help them identify and report possible fraud scams. Describe QHP's procedures to report fraud scams to law enforcement.					
5.12	Describe QHP issuer's safeguards against Social Security and identity fraud.					
5.13	QHP must comply with applicable federal and state privacy laws and regulations, and has appropriate procedures in place to detect and respond to privacy and security incidents.				☐Yes ☐No	
5.14	QHP issuer must adhere to Covered California naming conventions promulgated through a future administrative rulemaking by Covered California for 2015.					
VI. Rates for 2015						
6.1	Submit premium rates for every proposed QHP by rating region for 2015 by completing and uploading through SERFF the most current Unified Rate Review Template (URRT) and the most current SERFF Rates Template located at: http://www.serff.com/plan_management_data_templates.htm					

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
6.2	Provide information requested about documents filed with the applicable regulator as outlined in Attachment A (Regulatory Filings) for 2015 products proposed to be offered through Covered California. Complete Attachment A and provide updates to this information as additional documents are submitted to the applicable regulator.					
VII. 2015 Standard Benefit Plan Design						
7.1	QHP issuer must adhere to 2015 standard benefit plan designs which will be adopted through a future administrative rulemaking.				☐Yes ☐No	
7.2	QHP issuer agrees to submit its proposed 2015 plans for each metal level and for catastrophic coverage for its licensed geographic service area(s). QHP issuer can satisfy this requirement through either its life and health insurance company offerings or its Knox Keene health care service plans.				☐Yes ☐No	
7.3	Comply with California state benefit plan laws in effect for 2015, including those pertaining to plan design requirements.				☐Yes ☐No	
7.4	The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric Dental Essential Health Benefit. QHP issuer shall indicate if it is prepared to submit proposals that adhere to the 2015 Essential Health Benefit standard plan design adopted through a future administrative rulemaking that includes all ten Essential Health Benefits. Failure to offer a product with all ten Essential Health Benefits will not be grounds to have QHP issuer's renewal application rejected.				☐Yes ☐No	

	Requirements	Federal Law	State Law	Board Policy	Yes/No	Comments/Explanations (Responses shall not exceed 250 words)
7.5	If QHP issuer answered yes above, describe how issuer intends to meet the plan design described in 7.4. Provide information about any intended subcontractor relationship, if applicable, to offer the pediatric Dental Essential Health Benefit. Include a description of how QHP issuer will ensure subcontractor adheres to Covered California pediatric dental quality measures.					

Section 8. eValue8™ Submission

8.1 Business Profile

8.1.4 Accreditation

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

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

Flagged: CA HIX
Flagged: HMO
Flagged: Regional

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA MCO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: NCQA not used or product not eligible		
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate		
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used		
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used		

NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification		
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From Dec 31, 1972 to Jan 01, 2023.	
URAC Accreditation - Comprehensive Wellness	Same as above	Same as above	
URAC Accreditations - Disease Management	Same as above	Same as above	
URAC Accreditations - Health Utilization Management	Same as above	Same as above	
URAC Accreditations - Case Management	Same as above	Same as above	
URAC Accreditations - Pharmacy Benefit Management	Same as above	Same as above	

8.1.4.2 PPO version of above

8.1.5 Business Practices and Results (formerly 1.7, Racial, Cultural and Language Competency)

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

Flagged: CA HIX

	Data proactively collected from all new enrollees (specify date started - MM/DD/YYYY)	How data is captured from previously enrolled members(i.e., those who were not new enrollees when respondent started collecting information) - specify method	Members captured as percent of total commercial population (national)
Race/ethnicity	*To the day.* N/A OK.	*Multi, Checkboxes.* 1: Enrollment form, 2: Health Assessment, 3: Information requested upon Website registration, 4: Inquiry upon call to Customer Service, 5: Inquiry upon call to Clinical Service line, 6: Imputed method such as zip code or surname analysis, 7: Other (specify in detail box below. 200 word limit), 8: Data not collected	*Percent.*
Primary language	Same as above	Same as above	Same as above
Interpreter need	Same as above	Same as above	Same as above
Education level	Same as above	Same as above	Same as above

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

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

Flagged: CA HIX
Flagged: Regional

	Physicians in this market	Physician office staff in this market	Plan staff in this market
Race/ethnicity	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.
Languages spoken			

8.4 Helping Members become Good Consumers

8.4.1 Instructions and Definitions

8.4.2 Addressing language and health literacy needs (formerly 1.7, Racial, Cultural and Language Competency)

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

Please describe below plan activities to address health literacy.

Flagged: CPR
Flagged: CA HIX

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

8.4.2.2 Indicate how racial, ethnic, and/or language data is used? Check all that apply.

Flagged: CA HIX
Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language,
3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
4: Identify areas for quality improvement/disease management/ health education/promotion,
5: Share with enrollees to enable them to select concordant clinicians,
6: Share with provider network to assist them in providing language assistance and culturally competent care,

7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),
8: Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),
9: Analyze disenrollment patterns,
10: Develop disease management or other outreach programs that are culturally sensitive (provide details on program in detail box below),
11: : Other (describe in detail box below),
12: Racial, ethnic, language data is not used

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

Flagged: CA HIX

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

8.4.2.4 Indicate which of the following activities the Plan undertook in 2013 to assure that culturally competent health care is delivered. This shall be evaluated with regard to language, culture or ethnicity, and other factors. Check all that apply.

Flagged: CA HIX
Multi, Checkboxes.
1: Assess cultural competency needs of members,
2: Conduct an organizational cultural competence assessment of the Plan,
3: Conduct a cultural competence assessment of physician offices,
4: Employ a cultural and linguistic services coordinator or specialists,
5: Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,

6: Collaborate with statewide or regional medical association groups focused on cultural competency issues,
7: Tailor health promotion/prevention messaging to particular cultural groups (summarize groups targeted and activity in detail box),
8: Tailor disease management activities to particular cultural groups (summarize activity and groups targeted in detail box),
9: Public reporting of cultural competence programs, staffing and resources,
10: Sponsor cultural competence training for Plan staff,
11: Sponsor cultural competence training for physician offices,
12: Other (describe in detail box below):,
13: No activities in year of this response

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

Flagged: CA HIX

8.4.8 Price Transparency - Helping Members Pay the Right Price (Understand Cost) (formerly 2.7 Claims Management and Price Transparency)

8.4.8.1 Describe activities to identify for members/consumers those providers (hospitals and/or physicians) that are more efficient and/or lower cost.

Single, Radio group.
1: Description,
2: Plan does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

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

	Physicians	Hospitals	Ambulatory surgery or diagnostic centers
Procedure-based cost	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to

	members, 8: Information available to public	members, 8: Information available to public	members, 8: Information available to public
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	Same as above	Same as above	Same as above

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

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

	Answer
	Multi, Checkboxes - optional. 1: The Plan does not support a cost calculator.
Content	*Multi, Checkboxes.* 1: Medical cost searchable by procedure (indicate number of procedures in detail box below), 2: Medical cost searchable by episode of care (indicate number of care episodes in detail box below), 3: Medication costs searchable by drug, 4: Medication costs searchable by episode of care, 5: None of the above
Functionality	*Multi, Checkboxes.* 1: Compare costs of alternative treatments, 2: Compare costs of physicians, 3: Compare costs of hospitals, 4: Compare costs of ambulatory surgical or diagnostic centers, 5: Compare drugs, e.g. therapeutic alternatives, 6: Compare costs based on entire bundle of care, allowing user to substitute lower cost or higher quality equivalent elements of bundle, 7: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions, 2: Cost information considers members benefit design relative to accumulated deductibles, Out of Pocket max, lifetime, services limits (e.g. number of physical therapy visits covered),

	3: Cost information considers members benefit design relative to pharmacy benefit, e.g. brand/generic and retail/mail, 4: Separate service category sets result for user, other adult household members and for children, 5: Explains key coverage rules such as family-level versus individual-level annual accumulation and general rules about portability, accrual, tax allowances, etc, 6: Provides summary plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above
Account management / functionality	*Multi, Checkboxes.* 1: Supports member entry of tax status/rate to calculate federal/state tax ramifications, 2: Member can view multi-year HSA balances, 3: Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses, 4: None of the above

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

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

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

Single, Pull-down list.
1: Consumer 8a is provided,
2: Consumer 8b is provided,
3: Consumer 8c is provided,
4: Consumer 8d is provided,
5: Consumer 8e is provided,
6: Not provided

Appendix A: Definition of Good Standing

Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for lines of business sought in the Exchange (e.g. commercial, small group, individual)	DMHC
• Approved to operate in what geographic service areas	DMHC
• Most recent financial exam and medical survey report reviewed	DMHC
•Most recent market conduct exam reviewed	CDI
Affirmation of no material[5] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:	
• Financial solvency and reserves reviewed	DMHC and CDI
• Administrative and organizational capacity acceptable	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits (State required)	DMHC and CDI
• Basic health care services	CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using 2015 Federal Actuarial Value Calculator)	DMHC and CDI
• Network adequacy and accessibility standards are met	DMHC and CDI
• Provider contracts	DMHC and CDI
• Language Access	DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
• Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Independent medical review	DMHC and CDI
• Marketing and advertising	DMHC and CDI
• Guaranteed issue individual and small group	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

[5]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

Appendix B: Essential Community Provider Network Requirement

Except if QHP issuer has qualified under the alternate standard for essential community providers provided by the Affordable Care Act as has been determined by the Exchange, QHP issuer shall maintain a network that includes a sufficient geographic distribution of essential community providers ("ECP") that are available through QHP issuer to provide reasonable and timely access to Covered Services to low-income populations in each geographic region where QHP issuer provides services to Enrollees.

(a) For purposes of this Section, "sufficient geographic distribution" of ECP shall be determined by the Exchange in its reasonable discretion in accordance with the conditions set forth in the Solicitation and based on a consideration of various factors, including, (i) the nature, type and distribution of QHP issuer's ECP contracting arrangements in each geographic region in which QHP issuer's QHP products provide Covered Services to Enrollees, (ii) the balance of hospital and non-hospital ECPs in each geographic region, (iii) the inclusion in Contractor's provider contracting network of at least 15% of entities in each applicable geographic region that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B) ("340B Entity"), (iv) the inclusion of at least one ECP hospital in each region, (v) the inclusion of Federally Qualified Health Centers, school-based health centers and county hospitals, and (vi) other factors as mutually agreed upon by the Exchange and the QHP issuer regarding QHP issuer's ability to serve the low income population.

(b) "Low-income populations" shall be defined as families living at or below 200% of Federal poverty level. ECPs shall consist of participating entities in the following programs: (i) 340B, per the providers list as of November 9, 2012, (ii) California Disproportionate Share Hospital Program, per the Final DSH Eligibility List FY (CA DHCS 2011-12), (iii) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs, (iv) Community Clinic or health centers licensed as either a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Health and Safety Code Section 1206, and (v) Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program. Lists named in this paragraph are available here: http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf

(c) During all times QHP issuer offers a product on the Exchange, QHP issuer shall notify the Exchange with respect to any material changes to its contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating to ECPs from prior disclosures made by QHP issuer.

(d) QHP issuer shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.

Appendix C: QHP Contract Data Submission Requirements

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

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment A- Regulatory Filings

Issuer Name:

Instructions:
Please provide the requested details associated with any Regulatory and/or Product filings necessary to obtain approval of products/plans that are to be submitted in response to this application.

Type of Filing	Regulatory Agency	Regulatory Filing Number (if applicable)	Product Filing Number (if applicable)	Date of Submission	Expected Date for Review / Approval	Amendment Number (If applicable)	Initial Filing Date (If applicable)	Comments

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment B - QHP 2015 Enrollment Projections

Issuer Name:
Product:
Market:

Please complete Attachment B enrollment projection for each product and market type. Enrollment projection should reflect anticipated enrollment January 1, 2015 through December 1, 2015

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 1	Alpine		
Region 1	Del Norte		
Region 1	Siskiyou		
Region 1	Modoc		
Region 1	Lassen		
Region 1	Shasta		
Region 1	Trinity		
Region 1	Humboldt		
Region 1	Tehama		
Region 1	Plumas		
Region 1	Nevada		
Region 1	Sierra		
Region 1	Mendocino		
Region 1	Lake		
Region 1	Butte		
Region 1	Glenn		
Region 1	Sutter		
Region 1	Yuba		
Region 1	Colusa		
Region 1	Amador		
Region 1	Calaveras		
Region 1	Tuolumne		
Region 2	Napa		
Region 2	Sonoma		
Region 2	Solano		
Region 2	Marin		
Region 3	Sacramento		
Region 3	Placer		
Region 3	El Dorado		
Region 3	Yolo		
Region 4	San Francisco		
Region 5	Contra Costa		
Region 6	Alameda		
Region 7	Santa Clara		
Region 8	San Mateo		
Region 9	Santa Cruz		
Region 9	Monterey		
Region 9	San Benito		
Region 10	San Joaquin		
Region 10	Stanislaus		

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 10	Merced		
Region 10	Mariposa		
Region 10	Tulare		
Region 11	Fresno		
Region 11	Kings		
Region 11	Madera		
Region 12	San Luis Obispo		
Region 12	Ventura		
Region 12	Santa Barbara		
Region 13	Mono		
Region 13	Inyo		
Region 13	Imperial		
Region 14	Kern		
Region 15	Los Angeles		
Region 16	Los Angeles		
Region 17	San Bernardino		
Region 17	Riverside		
Region 18	Orange		
Region 19	San Diego		

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment C1 - Plan Type by Rating Region (Individual)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

INDIVIDUAL								
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 1	Alpine							
Region 1	Del Norte							
Region 1	Siskiyou							
Region 1	Modoc							
Region 1	Lassen							
Region 1	Shasta							
Region 1	Trinity							
Region 1	Humboldt							
Region 1	Tehama							
Region 1	Plumas							
Region 1	Nevada							
Region 1	Sierra							
Region 1	Mendocino							
Region 1	Lake							
Region 1	Butte							
Region 1	Glenn							
Region 1	Sutter							
Region 1	Yuba							
Region 1	Colusa							
Region 1	Amador							
Region 1	Calaveras							
Region 1	Tuolumne							
Region 2	Napa							
Region 2	Sonoma							

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 2	Solano							
Region 2	Marin							
Region 3	Sacramento							
Region 3	Placer							
Region 3	El Dorado							
Region 3	Yolo							
Region 4	San Francisco							
Region 5	Contra Costa							
Region 6	Alameda							
Region 7	Santa Clara							
Region 8	San Mateo							
Region 9	Santa Cruz							
Region 9	Monterey							
Region 9	San Benito							
Region 10	San Joaquin							
Region 10	Stanislaus							
Region 10	Merced							
Region 10	Mariposa							
Region 10	Tulare							
Region 11	Fresno							
Region 11	Kings							
Region 11	Madera							
Region 12	San Luis Obispo							
Region 12	Ventura							
Region 12	Santa Barbara							
Region 13	Mono							
Region 13	Inyo							
Region 13	Imperial							
Region 14	Kern							
Region 15	Los Angeles							
Region 16	Los Angeles							
Region 17	San Bernardino							
Region 17	Riverside							
Region 18	Orange							
Region 19	San Diego							

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment C2 - Plan Type by Rating Region (SHOP)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan or propose an Alternate Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

SHOP										
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 1	Alpine									
Region 1	Del Norte									
Region 1	Siskiyou									
Region 1	Modoc									
Region 1	Lassen									
Region 1	Shasta									
Region 1	Trinity									
Region 1	Humboldt									
Region 1	Tehama									
Region 1	Plumas									
Region 1	Nevada									
Region 1	Sierra									
Region 1	Mendocino									
Region 1	Lake									
Region 1	Butte									
Region 1	Glenn									
Region 1	Sutter									
Region 1	Yuba									
Region 1	Colusa									
Region 1	Amador									
Region 1	Calaveras									
Region 1	Tuolumne									
Region 2	Napa									
Region 2	Sonoma									
Region 2	Solano									
Region 2	Marin									
Region 3	Sacramento									
Region 3	Placer									
Region 3	El Dorado									

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 3	Yolo									
Region 4	San Francisco									
Region 5	Contra Costa									
Region 6	Alameda									
Region 7	Santa Clara									
Region 8	San Mateo									
Region 9	Santa Cruz									
Region 9	Monterey									
Region 9	San Benito									
Region 10	San Joaquin									
Region 10	Stanislaus									
Region 10	Merced									
Region 10	Mariposa									
Region 10	Tulare									
Region 11	Fresno									
Region 11	Kings									
Region 11	Madera									
Region 12	San Luis Obispo									
Region 12	Ventura									
Region 12	Santa Barbara									
Region 13	Mono									
Region 13	Inyo									
Region 13	Imperial									
Region 14	Kern									
Region 15	Los Angeles									
Region 16	Los Angeles									
Region 17	San Bernardino									
Region 17	Riverside									
Region 18	Orange									
Region 19	San Diego									

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment D1 - 834 Enrollment File Error Listing

March 2014 834 Enrollment File Error Listing				
834 Enrollment Files Sent to Carrier - File Names	**Number of Members in File**	**Carrier 999 Response File Sent to CalHEERS**	**No. of Rejected Files in 999 Response Due to Carrier Issues**	**Error Rate**
ex: TO_999999_IND_2014030515897.edi	500	ex: FROM_99999_IND_2014030565	4	0.8%

California Health Benefit Exchange
QHP Issuer 2015 Renewal Application
Attachment D2 - 834 Effectuation File Error Listing

March 2014 834 Effectuation File Error Listing				
834 Effectuation Files Sent from the Carrier - File Names	**Number of Members in File**	**CalHEERS 999 Response File Sent to CalHEERS**	**No. of Rejected Files in 999 Response Due to Carrier Issues**	**Error Rate**
ex: FROM_99999_IND_2014030515897.edi	500	ex:TO_99999_IND_201403056577899.edi	4	0.8%

Authority: Government Code Section 100504, 100505

Reference Government Code Sections 100502, 100503,100504,100505

Title 10, California Code of Regulations

Adopt Section 6422 to read:

Section 6422: Qualified Health Plan (QHP) New Entrant Application for Plan Year 2015

The purpose of this section is to set forth the requirements for eligible applicants to request certification as a Qualified Health Plan for the Plan Year 2015 for the individual Exchange and for the SHOP Exchange. Applicants must complete the Qualified Health Plan(QHP) New Entrant Application for Plan Year 2015 in order to request certification of its plan offerings as Qualified Health Plans for 2015 Plan Year. If an applicant meets the requirements for certification and Covered California, in its sole discretion, determines that additional Qualified Health Plans proposed by the applicant meet the requirements and are necessary, some or all of that applicant's proposed plans may be certified as Qualified Health Plans by Covered California for the Plan Year 2015. If an applicant fails to meet the requirements for certification as a Qualified Health Plan for 2015 or if Covered California, in its sole discretion, determines that the applicant's offerings are not necessary in a given geographic service area, Covered California may decline to certify some or all of the applicant's proposed plans for 2015.

(a) The definitions included in 10 CCR 6410 shall govern this section. Any other applicable terms not defined in Section 6410 are defined in subdivision (e).

(b) Applicants eligible to complete the Qualified Health Plan New Entrant Application for Plan Year 2015 to be certified to participate in the Individual Exchange in 2015 are limited to entities below:

1)Health issuers who received their license or certificate of authority to offer, market or sell health insurance or a health plan from a California state regulator after August 2012; or

2) Medi-Cal Managed Care Plan (MMCP): An entity contracting with the Department of Health Care Services to provide health care services to enrolled Medi-Cal beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3, of the Welfare and Institutions Code.

(c) Applicants who are eligible to complete the Qualified Health Plan Issuer 2015 Renewal Application in subsection (e) for participation in the SHOP Exchange include any entity licensed to offer, market or sell small group health insurance in California.

(d) Submission Requirements: Entities eligible to apply for certification to participate in the Individual or SHOP Exchange must comply with the submission date and requirements in (d)(2) if the events in subdivision (d)(3) do not occur.

(1) Submit a notice to Covered California indicating intent to request certification no later than 5:00 pm Pacific Time on March 17, 2014.
(2) Complete the application in subdivision (e) and submit to Covered California in its entirety no later than 5:00 pm Pacific Time on May 1, 2014.
(3) If the California Legislature amends Health and Safety Code §1399.849(c)(1) and Insurance Code § 10965.3 to set the start of open enrollment for the 2015 plan year as November 15, 2014 or any another date, applicants are required to complete the application in subdivision (e) and submit to Covered California in its entirety on or before 5:00pm Pacific Time on June 2, 2014.

(e) Qualified Health Plan New Entrant Application for Plan Year 2015: Applicants who are eligible to complete the QHP Issuer New Entrant Application for Plan Year 2015 for participation in the Individual or SHOP Exchange must complete the following QHP Issuer New Entrant Application for Plan Year 2015.

[INSERT Qualified Health Plan New Entrant Application for Plan Year 2015 with Attachments HERE]

Covered California Qualified Health Plan New Entrant Application for the 2015 Plan Year

February 20, 2014

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1. General Information and Background

1.1 Attestation

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

Issuer Name	
NAIC Company Code	
NAIC Group Code	
Regulator(s)	
Federal Employer ID	
HIOS/Issuer ID	
Corporate Office Address	
City	
State	
ZIP	
Primary Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	
Check applicable categories: ☐Individual Commercial ☐SHOP	

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

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

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

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

The matter contained in this document is strictly related to the 2015 year Issuer QHP New Entrant applications.

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

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

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

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

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

- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.

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

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

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

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

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

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans that will be offered in the Exchange.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively contract with carriers so as to provide health care coverage choices that offer

the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health issuers.[2]

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

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

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

1.4 Application Evaluation and Selection

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

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

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

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

While premium and out-of-pocket costs for consumers will be a key consideration, contracts will be awarded based on determination of "best value" to the Exchange and its participants. The evaluation of Issuer QHP proposals will focus on quality and service components, including past history of performance, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population through cooperation with the Exchange operations, provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. We expect that some necessary regulatory and rate filings may need to be completed after the due date for this QHP New Entrant application. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer issuers' products on the Exchange for the 2015 plan year.

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

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard and Non-Standard Benefit Plan Designs[3]

The Exchange is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. QHP Applicants are required to propose at least one of the Exchange's adopted standardized benefit plan designs (either co-pay or co-insurance plan) in each region for which they submit a proposal. In addition, QHP Applicants may offer the Exchange's standardized Health Savings Account-eligible (HSA) design, and QHP SHOP Applicants may propose an alternative benefit design. The standardized benefit plan designs use cost sharing provisions that are predominantly deductibles with either co-payments ("co-pay plan") or co-insurance ("co-insurance plan") and are intended to be "platform neutral". That is, either of the standardized benefit designs can be applied to a network product design that may be a health maintenance organization (HMO) or exclusive provider organization (EPO) with out-of-network benefits limited to pre-authorized and emergency services, or to Preferred Provider Organization (PPO) or Point of Service (POS) product design that offer out-of-network coverage with significantly higher levels of member cost-sharing. To the extent possible, both HMO and PPO products will be offered. If there are meaningful differences in network design, levels of integration, and other innovative delivery system features, multiple HMO or PPO products will be considered in the same geographic service area. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping PPO networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

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

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

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

[3] The 2015 Standard Benefit Designs will be promulgated through a future administrative rulemaking after the 2015 federal actuarial value calculator is finalized.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

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

Encourage Long Term Partnerships with Health issuers

A goal of the Exchange is to reward early participation with contract features that offer a potential for market share and program stability. The Exchange encourages Issuer interest in multi-year contracts (plan year 2015 and 2016) and submitting rates at the most competitive position possible; fosters rate and plan stability and encourages QHP investments in product design, network development, and quality improvement programs. Application responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission are strongly encouraged, particularly those that include underserved service areas, and that leverage Issuer efforts to provide better care, improve health, and lower cost.

1.5 AVAILABILITY

The QHP Applicant must be available immediately upon contingent certification as a QHP to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2015. Successful Applicants will also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with the California Healthcare Enrollment, Eligibility, and Retention System (CalHEERS). The Exchange expects to negotiate and sign contracts prior to September 1, 2014. The successful Applicants must be ready and able to accept enrollment as of October 15, 2014.

1.6 APPLICATION PROCESS

The application process shall consist of the following steps:

- Release of the Draft Application;
- Release of the Final Application;
- Submission of Applicant responses;
- Evaluation of Applicant responses;
- Discussion and negotiation of final contract terms, conditions and premium rates;

- Execution of contracts with the selected New Entrant QHP Issuers.

1.7 Intention to Submit a Response

Applicants interested in responding to this application are required to submit a non-binding Letter of Intent to Apply indicating their interest in applying and their proposed products, service areas and the like and to ensure receipt of additional information. Only those Applicants acknowledging interest in this application by submitting a notification of intention to submit a proposal will continue to receive application-related correspondence throughout the application process. The Exchange intends to select QHPs for the second year of operation with a strong interest in pursuing multi-year contracts with successful Applicants and may conduct a very limited second or third year solicitation process.

The Applicant's notification letter must identify the contact person for the application process, along with contact information that includes an email address, a telephone number, and a fax number. Receipt of the non-binding letter of intent will be used to issue instructions and login and password information to gain access to the on-line portion(s) of the Applicant submission of response to the Application.

An Issuer's submission of an Intent to Apply will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Applicant information is not expected to be released until selected Issuers and QHP proposals are announced in late June 2014. Confidentiality is to be held by the Exchange; Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators. The Exchange and regulators will maintain the confidentiality of rate filings until rates are approved by the regulator and posted publicly on their website.

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

Application Contact:

Pamela Power

Pamela.power@covered.ca.gov

(916) 228-8374

1.9 Application Library

Applicants may access the Application Library at:

https://www.coveredca.com/hbex/solicitations/Qualified%20Health%20Plan%20New%20Entrant%20Application/

The Application Library will allow Applicants access to reference documents and information that may be useful for developing the Applicant's response. The Application Library will continue to be updated as further documentation related to the application becomes available. Amendments to this application will not be issued when new information is posted to the Application Library. Applicants are encouraged to continuously monitor the Application Library, but are not required to access or view documents in the Application Library.

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

1.10 Key Action Dates

Action	Date/Time
Release of Final Application	March 10, 2014
New Entrant Letters of Intent due to Covered California	March 17, 2014
Completed New Entrant Applications Due (include 2015 Proposed Rates & Networks) subject to Section 6422(d)(3)	May 1, 2014
Negotiations between New Entrants and Covered California	June 2014
Submission of ECP Networks by Contingently Certified New Entrant QHPs	June 30, 2014
Regulatory Rate Review	July & August 2014
Final QHP Recertification/Decertification/New Entrant Certification Decisions	August 30, 2014
New Entrant QHP Contract Execution	September 1, 2014

2. Licensed and in Good Standing

2.1 In addition to holding all of the proper and required licenses[4] to operate as a health issuer as defined herein, the Applicant must indicate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the Applicant has had no material fines, no material penalties levied or material ongoing disputes with applicable licensing authorities in the last two years.

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

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

- ☐ Yes, issuer is in good standing
- ☐ No

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

- ☐ Yes (explain)
- ☐ No

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

Applicant must check the appropriate box.

- ☐ Yes
- ☐ No

If yes, Applicant must complete Attachment A Regulatory Filings to indicate type of filing and provide additional information.

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

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

2.5 Applicant must confirm it will agree to immediately submit to the Exchange the results of final financial, market conduct, or special audits/reviews performed by the Department of Managed Health Care, California Department of Social Services, Department of Covered Services, US Department of Health and Human Services, and/or any other regulatory entity within the State of California that has jurisdiction where Contracted QHP serves enrollees.

- ☐ Yes
- ☐ No

3. APPLICANT HEALTH PLAN PROPOSAL

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

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

Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels. Standard plan cost-share is applied to the most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Plan or Policy Submission Requirements

QHP Applicants must submit one of the 2015 Standard Benefit Plan Designs which will be adopted in a future administrative rulemaking and offer all four metal levels and a catastrophic plan in its proposed rating regions.

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

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

3.1 QHP New Entrant Applicant must comply with 2015 Standard Benefit Plans Designs which will be adopted in a future administrative rulemaking . Applicant must certify its proposal includes a health product offered at all four metal tiers (bronze, silver, gold and platinum) and catastrophic for each plan it proposes to offer in a rating region. SHOP New Entrant Applicants must certify proposals include a health product offered at all four metal tiers (bronze, silver, gold and platinum). If not, the Applicant's response will be disqualified from consideration. Certification of the actuarial value of each QHP product tier will be performed by the relevant regulatory agency. Complete Attachment B1 Plan Type by Rating Region (Individual) to indicate the rating regions and number and type of plans for which you are proposing a QHP in the Individual Exchange. If applicable, use Attachment B2 Plan

Type by Rating Region (SHOP) to submit a SHOP proposal. Yes, complete Attachment to indicate the rating regions and number and type of plans proposed

☐ No

3.2 The Exchange is encouraging the offering of plan products which include all ten Essential Health Benefits including the pediatric dental Essential Health Benefit. QHP issuer must indicate if it is prepared to adhere to the 2015 all ten Essential Health Benefit standard plan design. Failure to offer a product with all ten Essential Health Benefits will not be grounds for rejection of Applicant's application.

☐ Yes, prepared to offer QHP inclusive of embedded pediatric dental Essential Health Benefit

☐ No, not prepared to offer QHP inclusive of embedded pediatric dental Essential Health Benefit

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

3.4 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the second full year of operation of the Exchange, effective January 1, 2015, or for the SHOP plan year. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies. Premium proposals will be due May 1, 2014. To submit premium proposals for Individual products, QHP applicants will complete and upload through System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT) and the Rates Template located at: http://www.serff.com/plan_management_data_templates.htm . See Section 9 SHOP Supplemental Application for instructions to submit SHOP Premium Proposals. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange's request, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

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

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

3.6 Applicant must confirm if it is interested in a multi-year contract. 2015 New Entrant QHPs will be offered in 2015 and 2016 if Applicant's QHPs continue to meet certification criteria.

The Exchange seeks to promote multi-year partnerships with QHPs, foster rate stability and encourage QHP investments in product design, network development, and quality improvement programs.

- ☐ Yes, Applicant is interested in a multi-year contract.
- ☐ No, Applicant is not interested in a multi-year contract

4. PROVIDER NETWORK

4.1 Use Attachment C 2015 Enrollment Projections to submit 2015 enrollment projections by product that Applicant proposes for 2015. Enrollment projections for both Individual and SHOP Exchange products are reported in this attachment, if applicable.

4.2 Provider directory data for both Individual and SHOP Exchange products must be included in this submission.

4.3 Applicant must certify that for each rating region in which it submits a health plan proposal, the proposed products meet provider network adequacy standards established by the relevant regulatory agency. Provider network adequacy will be evaluated by the governing regulatory agency. Additionally, for Plan Year 2015, network adequacy standards applicable to dental provider networks will apply to the embedded pediatric dental benefit. See Section 5 for complete Essential Community Provider (ECP) requirements.

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

4.4 Using the Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications, identify the number and percentage of contracted primary care physicians, specialists and practitioners who are board-eligible/certified in your network in 2013.

	Number of Board Eligible/Certified in Contracted Network for 2014	Percent of Board Eligible/Certified in Contracted Network for 2014
Primary Care Physicians (including Family Practice, Pediatrics, Internal Medicine and OB/GYNs)		
Specialists (including allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, ophthalmologists, orthopedic surgeons, and otolaryngologists and other medical specialties)		

4.5 Identify your Centers of Excellence participating facilities. Specifically indicate the locations of each facility and the type of procedures included.

Type of Procedure	Facility Name and Locations

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

Applicant must confirm that, if certified as a QHP, to the extent that any Participating Provider's rates are prohibited from disclosure to the Exchange by contract, the Contracted QHP shall identify such Participating Provider. Issuer shall, upon renewal of its Provider contract, but in no event later than July 1, 2015, make commercially reasonable efforts to obtain agreement by that Participating Provider to amend such provisions, to allow disclosure. In entering into a new contract with a Participating Provider, Contracted QHP agrees to make commercially reasonable efforts to exclude any contract provisions that would prohibit disclosure of such information to the Exchange.

- ☐ Yes, confirmed
- ☐ No, not confirmed

Contract Provisions	Description

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

4.7 Identify the hospitals terminated between January 1, 2013 and December 31, 2013, including any hospitals that had a break in maintaining a continuous contract during this period.

Total Number of Contracted Hospitals:

Total Number of Terminated Hospitals between 1/1/13-12/31/13:

Name of Terminated Hospital	Terminated by Issuer or Hospital

4.8 Identify the Independent Practice Associations (IPA), Medical Groups, clinics or health centers terminated between January 1, 2013 and December 31, 2013, including any IPAs or Medical Groups, Federally Qualified Health Centers or community clinics that had a break in maintaining a continuous contract during this period.

Total Number of Contracted IPA/Medical Groups/Clinics:

Total Number of Terminated IPA/Medical Groups/Clinics between 1/1/13-12/31/13:

Name of Terminated IPA/Medical Group/Clinic	Terminated by Issuer or

	IPA/Medical Group/Clinics

4.9 Do you perform provider profiling?

☐ Yes

☐ No

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

4.10 Describe your plans for network development in 2015 and 2016. Do you anticipate making significant changes to your current network that could be described as narrow network or tiered networks, or changes to your formulary? Would you be willing to modify this plan to include Exchange-specific sites?

Anticipate making significant changes ☐ Yes ☐ No

Willing to modify these plans ☐ Yes ☐ No

4.11 What non-financial incentives are used to encourage Members to enhance value by use of lower cost and/or higher quality Providers? (Check all that apply)

☐ Non-financial incentives not used

☐ Information on provider quality and/or costs made available to members through employer, health plan, or other sources

☐ Other (describe)

4.12 Applicant must confirm that, if certified, Contracted QHP shall, at a minimum, document its plans to make available to Plan Enrollees information provided for public use, as it becomes available, that reflects the CMS Hospital Compare Program and CMS Physician Quality Reporting System, or Health Resources and Services Administration (HRSA) Uniform Data System as appropriate. Contracted QHP shall report how it is or intends to make provider specific cost and quality information available by region, and the processes by which it updates the information.

- ☐ Yes, confirmed
- ☐ No, not confirmed

4.13 How have you structured provider networks to drive improved quality for enrollees with chronic conditions and cost-efficiency and enhance access? If you have not done so, how might you approach this for the Exchange? Identify the strategies you have implemented or intend to implement in order to promote access and care coordination:

- ☐ Accountable Care Organizations (ACO)
- ☐ Patient Centered Medical Homes (PCMH)
- ☐ The use of a patient-centered, team-based approach to care delivery and member engagement
- ☐ A focus on additional primary care recruitment, use of Advanced Practice Clinicans (nurse practitioners, physician assistants, certified nurse midwives) and development of new primary care and specialty clinics
- ☐ A focus on expanding primary care access through payment systems and strategies
- ☐ The use of an intensive outpatient care programs (e.g. “Ambulatory ICU”) for enrollees with complex chronic conditions
- ☐ The use of qualified health professionals to deliver coordinated patient education and health maintenance support, with a proven approach for improving care for high-risk and vulnerable populations
- ☐ Support of physician and patient engagement in shared decision-making;
- ☐ Providing patient access to their personal health information
- ☐ Promoting team care
- ☐ The use of telemedicine
- ☐ Promoting the use of remote patient monitoring

4.14 Delivery System Reform**:** In keeping with its mission and values, the Exchange is charged with encouraging delivery system reforms which increase quality and consumer choice, lower cost and improve health. Complete Attachment D1 Delivery System Reform (Individual) by indicating which delivery system reforms your QHP proposal will feature in which geographic regions and whether those products will be available to the Exchange in 2015, 2016 or not at all. If applicable, complete Attachment D2 Delivery System Reform (SHOP).

5. ESSENTIAL COMMUNITY PROVIDERS

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

i. Qualified Health Plan Applicants must list contracts with all providers designated as ECP and indicate the category of each contracted ECP (e.g. 340B or DSH hospital or Medi-Cal HI-Tech provider or Federally Qualified Health Center, etc.)

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

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

iv. Applicants must include at least one ECP hospital (including but not limited to 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county and children's hospitals) per each county in the proposed geographic service area where available **AND**

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

ECP networks which include more contracted Federally Qualified Health Centers (FQHC) and Tribal and Urban Indian clinics are preferred and will be considered more favorably. Certified QHPs contracting with Tribal or Urban Indian Clinics must use the Centers for Medicare & Medicaid Services Model QHP Addendum for Indian Health Care Providers. (See Appendix B Model QHP Addendum for Indian Health Care Providers).

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

Attachments E1 Contracted Providers By County as of 1-1-14 and Attachment E2 Contracted Facilities by County as of 1-1-14: Complete the attachments by including name(s) of 340B entity contracted and all service sites affiliated with each contracted 340B entity. Only include site locations for a 340B entity if such site is included under the terms of the Issuer-provider contract. Please complete the contracted provider listing data elements using the supplied format in Attachments F1 and F2. The Exchange will calculate the percentage of contracted 340B entities located in each county of the proposed geographic service area. All 340B entity service sites shall be counted in the denominator, in accordance with the HRSA 340B provider site listing/link, which can be found at:

http://www.hrsa.gov/opa/

Categories of Essential Community Providers:

Essential Community Providers include the following:

1. The Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.
2. Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List FY 2012-2013
3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
4. Community Clinic or health center licensed as either a "community clinic" or "free clinic", by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Section 1206
5. Physician Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program (insert date of most current list)
6. Federally Qualified Health Centers (FQHCs) (insert date of most current list)

Covered California will reference Census Tract Level Data on Distribution of California Low-Income Population to identify geographic areas of low-income populations. Appendix C Census Tract Data on California Low Income Population includes data from the Year 2000 United States Census on number of Low-Income Individuals that live in a census tract. Low-income is defined as a family at or below 200% of Federal Poverty Level. The data supplied will allow the Exchange to plot contracted ECPs on county maps to compare against maps which display the low-income population.

Applicants will be permitted to write-in ECPs not on the CMS-developed non-exhaustive list of available 340B providers.

Alternate standard:

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

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

1. Percent of services received by Applicant's members which are rendered by Issuer's employed providers or single contracted medical group; **AND**
2. Degree of capitation Issuer holds in its contracts with participating providers. What percent of provider services are at risk under capitation; **AND**
3. How Issuer's network is designed to ensure reasonable and timely access for low-income, medically underserved individuals; **AND**

4. Efforts Issuer will undertake to measure how/if low-income, medically underserved individuals are accessing needed health care services (e.g. maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as CAHPS "getting needed care" survey)

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

6. Operational Readiness and Capacity & Technical Requirements

6.1 Administrative and Account Management Support

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

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

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

	Contact Name	**Title**	**Phone (include extension)**	**Fax**	**E-mail**
President or CEO	*100 words.*	*100 words.*	*100 words.*	*Unlimited.*	*Unlimited.*
Chief Medical	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*

Officer					
Chief Actuary (Lead for Exchange Rate Development)	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Lead Account Manager for Exchange	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Director, Provider Network Management	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Key Contact for CalHEERS technical questions	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Key Contact for Operational Questions	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Other	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.

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

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

6.2 MEMBER SERVICES

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

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

___Yes: staffing requirements - Please provide CSR Ratio to members

___Yes: training criteria

___Yes: languages spoken

___Yes: interface with CalHEERS

___No, the organization can handle the increased volume

___No, not willing to modify operations

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

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

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

☐ Yes

☐ No

6.2.4 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures regardless of which State Health Insurance Regulator regulates the QHP.

☐ Yes, confirmed

☐ No, not confirmed

6.3 Out-of-Network Benefits

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

Non-Network Claims	Yes/	Describe
Ability to administer FAIR Health UCR method		

Targeted UCR percentile		%
Ability to administer different percentiles		
Amount as a percentage of network contract value		%

6.3.2 Contracted QHPs are required to disclose financial information regarding costs of care to Enrollees. If you intend to provide coverage for out-of-network non-emergent care, describe the steps you will take to disclose to Enrollees the amount Issuer will pay for this care and the amount of additional fees Issuer may impose on this care.

6.4 Systems and Data Reporting Management

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

6.4.1 Technical Interface Capacity

6.4.1.1 Applicant must be prepared and able to engage with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including CalHEERS, as early as May 2014. Applicant must confirm it will implement systems in order to accept 834, 820 and other standard format electronic files for enrollment and premium remittance in an accurate, consistent and timely fashion and utilize information for its intended purpose. Covered California requires QHPs to sign an industry-standard agreement which establishes electronic information exchange standards in order to participate in the required systems testing.

6.4.1.2 Applicant must be able to accurately, appropriately, and timely populate and submit SERFF templates at the request of Covered California for:

- Rates
- Service Area
- Benefit Plan Designs
- Network

6.4.1.3 Applicant must be able to submit provider data in a format as required by Covered California and at intervals requested by Covered California for the purposes of populating the centralized provider directory.

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

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

6.4.1.6 Applicant must be available for testing data interfaces with the Exchange no later than July 1, 2014.

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

	Report Features	Sources of Data
Cost	*Multiple-choice* 1: Group-specific results reported 2: Comparison targets/benchmarks of book-of-business 3: Comparison benchmarks of similarly sized groups 4: Report available for additional fee 5: Data/reporting not available	*Multiple-choice* 1: HRAs 2: Medical Claims Data 3: Pharmacy Claims Data 4: Lab Values 5: Other source - please detail below
Utilization	*Same as above*	*Same as above*
Chronic Condition Prevalence	*Same as above*	*Same as above*
Plan Enrollee Use of Preventive Services	*Same as above*	*Same as above*
Participant Population stratified by Risk and/or Risk	*Same as above*	*Same as above*

Factors		
Disease Management (DM) program enrollment	*Same as above*	*Same as above*
Health status change among DM enrollees	*Same as above*	*Same as above*

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

Performance Measure	Measure Now Yes/No	Can Measure Exchange-Specific
Operational Standards – Customer Service		
Call Answer Timeliness • 80% of calls answered within 30 seconds		
Processing ID Cards • 99% sent within 10 business days of receiving complete and accurate enrollment information from the Exchange and premium		
Telephone Abandonment Rate • No more than 3% of incoming calls in a calendar month		
Initial Call Resolution for Covered California • 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue		
Grievance Resolution • 95% of enrollee grievances resolved within 30 calendar days		
Operational Standards		
Enrollment and Payment Transactions • The Exchange will receive the 999 file within one business day of receipt of the 834/820 file 85% of the time and within 3 business days of receipt of the 834/820 file 99% of the time within any given month		
Effectuation and Enrollment Upon Receipt of Payment • The Exchange will receive the 834 file within one business day of receipt of the member's initial payment file 85% of the time and within three business days of receipt of the member's initial payment 99% of the time within any given month		
Member Payment • The Exchange will receive the 820 file with one business day of receipt of the member's payment file 95% of the time and within 3 business days of receipt of the member's payment 99% of the time within any given month		
Enrollment Change Upon Non-Receipt of Member Payment, 30 Day Notice and Termination • The Exchange will receive the 834 file within one business day of receipt of change of the member's status 95% of the time and within 3 business days of receipt of change of the member's status 99% of the time within any given month		
Member Email or Written Inquiries • Correspondence 90% response to email or written inquiries within 15		

working days of inquiry. Does not include grievances or appeals.		
Member Call Volume • Track only – no performance requirement or penalty		
Quality Standards		
Quality – Getting the Right Care		
Appropriate Care		
Appropriate Testing for Children With Pharyngitis		
Appropriate Treatment for Children With Upper Respiratory Infection		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Use of Imaging Studies for Low Back Pain		
All-Cause Readmissions		
Annual Monitoring for Patients with Persistent Medications		
Plan All-Cause Readmission (average adjusted probability of readmission)		
Diabetes Care		
CDC: Medical Attention for Nephropathy		
CDC: Hemoglobin-A1c Testing		
CDC: LDL-C Screening		
CDC: Eye Exam (Retinal) Performed		
CDC: LCL-C Control (<100 mg/DI)		
CDC: HbA1c Control (<8.0%)		
CDC: Blood Pressure Control (140/90 mm Hg)		
CDC: HbA1c Poorly Control (>9.0%)		
Cardiovascular Care		
Controlling High Blood Pressure		
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)		
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)		
Persistence of beta blocker treatment after a heart attack		
Behavioral Health Care		
Antidepressant Medication Management (Both Rates)		
Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only)		
Follow-Up for Children Prescribed ADHD Medication (Both Rates)		
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs and 18+ Yrs)		
Other Chronic Care		
Medication Management for People With Asthma (50%/75% remained on controller medications)		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		

Drug Therapy for Rheumatoid Arthritis		
Pharmacotherapy management of COPD Exacerbation (bronchodilator and systemic corticosteroid)		
Doctor and Care Ratings		
Global Rating of Care (CAHPS)		
Global Rating of Personal Doctor (CAHPS)		
Global Rating of Specialist (CAHPS)		
Quality – Access to Care		
Getting Care Quickly Composite (CAHPS)		
Getting Needed Care Composite (CAHPS)		
Child and Adolescent Access to Primary Care Practitioners (12-14, 25mo-6yr, 7-11, 12-19) (HEDIS)		
Adults' Access to Preventive/Ambulatory Health Services (20-44 years and 45-64 years) (HEDIS)		
Quality - Staying Healthy/Prevention		
Adult Staying Health/Prevention		
Checking for Cancer		
Breast Cancer Screening		
Cervical Cancer Screening		
Colorectal Cancer Screening		
Getting Help Staying Healthy		
Chlamydia Screening in Women (Age 21-24)		
Adult BMI Assessment		
Prenatal and Postpartum Care (Both Rates)		
Flu Shots for Adults (Ages 50-64) (CAHPS)		
Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only) (CAHPS)		
Aspirin Use and Discussion (CAHPS)		
Children and Adolescent Staying Healthy/Prevention		
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents		
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life		
Well Child Visits in the First 15 Months of Life		
Adolescent Well-Care Visits		
Immunizations for Adolescents		
Childhood Immunization Status – Combo 3		
Chlamydia Screening in Women (Age 16-20)		
Quality – Plan Service		
Claims Processing Composite (CAHPS)		
Customer Service Composite (CAHPS)		
Plan Information on Costs Composite (CAHPS)		
Global Rating of Plan (CAHPS)		

6.4.1.12 Applicant operates in compliance with applicable federal and state privacy laws and regulations, and maintains appropriate procedures in place to detect and respond to privacy and security incidents.

- ☐ Yes, confirmed
- ☐ No, not confirmed

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

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2 Financial Interface Capacity

6.4.2.1 Applicant must confirm it has in place systems to invoice new members effective October 15, 2014. If such systems are not currently in place, describe plans to implement such systems, including any potential vendors if applicable, and an implementation workplan.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2.2 Applicant must confirm it has in place systems to accept premium payments (including paper checks, cashier's checks, money orders, EFT, and all general purpose pre-paid debit cards and credit card payment) from members effective October 15, 2014. If such systems are not currently in place, describe plans to implement such systems, including any potential vendors, if applicable, and an implementation workplan. QHP must accept premium payment from members no later than October 15, 2014. Note: QHP issuer must accept credit cards for binder payments and is encouraged, but not required, to accept credit cards for payment of ongoing invoices.

- ☐ Yes, confirmed
- ☐ No, not confirmed

6.4.2.3 Describe how Applicant will comply with the federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked.

6.4.2.4 Describe the controls in place to ensure the California Health Benefit Exchange assessment revenue is accurately and timely paid.

6.5 Implementation Performance

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

6.5.2 Should your organization's QHPs be certified by the Exchange explain how you anticipate accommodating the sizeable additional membership effective January 1, 2015 (discuss assessment of current resources (human, office space, phone capacity), anticipated hiring needs, staff reorganization, etc.):

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

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

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

6.5.4 Describe your network transition of care provisions for patients who are currently receiving care for services at practitioners that are not in your network

6.5.5 Provide a detailed implementation project plan and schedule targeting a January 1, 2015 effective date.

6.6 Fraud, Waste and Abuse Detection

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

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

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

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

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

Process	Description
Determining what is investigated • Specific event triggers • Overall surveillance, audits and scans • Fraud risk assessment	
Method for determining whether fraud, waste, and abuse has occurred	
Follow-up and corrective measures	
Recovery and remittance of funds	

6.6.2 Describe your approach to the following:

Approach	Description
Controls in place to confirm non-contracted Providers who file Claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.	

Use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.	
Controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.	
Controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.	
Other	

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

Providers	
Plan Members	

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

- ☐ Sample provided
- ☐ Sample not provided

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

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

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

%

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

	Audit Conducted	**Audit Not Conducted**
Most recent year		
Prior year		

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

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

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

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

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

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

	%	**$**
2012		
2013		

6.6.12 Applicant must confirm that, if certified, Contracted QHP will agree to subject itself to the Exchange for audits and reviews, either by the Exchange or its designee, or the Department of General Services, the Bureau of State Audits or their designee, as they deem necessary to determine the correctness of premium rate setting, the Exchange's payments to agents based on the Issuer's report, questions pertaining to enrollee premium payments and Advance Premium Tax Credit (APTC) payments and participation fee payments Issuer made to the Exchange. Issuer also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Enrollees.

- ☐ Yes, confirmed
- ☐ No, not confirmed

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

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

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

6.7 Approaches to Enrollment

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

6.7.1. Describe any experience you may have working with Certified Enrollment Entities or similar entities.

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

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

6.8 Marketing and Outreach Activities

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

In the questions that follow, Applicants must provide detailed information pertaining to the Applicant's plans for marketing and advertising for the individual and small group market. Where specific materials are requested, please be sure to label the attachments clearly.

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

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

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

6.8.3 Applicant must confirm that it will be expected to co-brand the ID card, premium invoices and termination notices. The Exchange retains the right to communicate with Exchange customers and members.

☐ Yes, confirmed

☐ No, not confirmed

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

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

Repeat table for Individual and Small Group reporting.

Marketing Results	Total Cost	Total Sales	Cost per Sale
Television			
Radio			
Out-of-Home			
Newsprint			
FSI (Free Standing Inserts)			
Direct Mail			
Shared Mail			
Search Engine Marketing			
Digital (display, video, mobile, radio)			

Social Media			
Email Marketing			
Lead Purchase			
Broker Seminars			
Direct Sales to Businesses			
Other (specify)			

6.8.6 Applicant must confirm it will adhere to Covered California naming conventions promulgated through a future administrative rulemaking by Covered California for 2015.

7. QUALITY AND DELIVERY SYSTEM REFORM

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

7.1 ACCREDITATION

Applicant must be currently accredited by Utilization Review Accreditation Commission (URAC), National Committee on Quality Assurance (NCQA) or Accreditation Association for Ambulatory Health Care (AAAHC). If issuer is not currently accredited, issuer must have an interim survey in place by January 1, 2015 in order to offer plans on the Exchange in 2015. QHPs must have full accreditation by January 1, 2016. Issuer shall authorize the accrediting agency to provide information and data to the Exchange relating to Issuer's accreditation, including, the most recent accreditation survey and other data and information maintained by accrediting agency as required under 45 C.F.R. § 156.275.

7.1.1 Applicant must provide the following information:

Applicant's accrediting organization:

Applicant's current accreditation status:

Next scheduled survey date(s):

If full accreditation has not been achieved or maintained, describe proposed timeline to achieve interim survey and full accreditation.

7.2 EVALUE8 SUBMISSION

7.2.1 Applicant must complete eValue8 submission as specified in Section 8 of this application.

7.3 QUALITY IMPROVEMENT STRATEGY

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

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

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

7.3.2 Describe two Quality Improvement Projects (QIPs) conducted within the last five (5) years. This description shall include but is not limited to, the following information:

QIP Name/Title:	Start/End Dates:
Problem Addressed:	
Targeted Population:	
Study Question:	

Study Indicator(s):
Baseline Measurement:
Best Practices Related to Sustained Improvement Achieved (if any):

7.4 MEDICAL MANAGEMENT SERVICES

7.4.1 Do you provide physician report cards? If so, do you use external guidelines to measure physician performance? Describe those procedures and processes.

Process	Yes/No	If Yes, description
Internally Developed Guidelines		
External Guidelines • National Quality Forum • Patient Charter for Physician Performance Measurement		
Other		

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

- ☐ Yes, provide Nurse Advice Line:
  - ☐ 0-5%
  - ☐ 6-10%
  - ☐ 11-20%
  - ☐ 21-30%
  - ☐ >31%
- ☐ No Nurse Advice Line provided

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

- ☐ 24/7 decision support/health information services
- ☐ Self-care books
- ☐ Preventive care reminders
- ☐ Web-based health information
- ☐ Integration with other health care vendors
- ☐ Integration with a client's internal wellness program

- ☐ Newsletter
- ☐ Other (describe)

7.4.4 Explain how your health plan encourages hospitals and other providers to improve patient safety on an ongoing basis. Describe any oversight your health plan performs targeting the following areas as outlined by the Center for Medicare and Medicaid Services (CMS) Hospital Compare Program:

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

7.5 Behavioral Health Medical Management

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

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

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

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

7.6 Health and Disease Management

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

7.6.1 Does your health plan use a Health Assessment? If yes, are responses used to identify members for care management programs and is data relayed to providers? Is the data used to assess or stratify risk? Identify which of the following you perform using Health Assessment ("HA") data.

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

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

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

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

7.7 Integrated Healthcare Model

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

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

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

Attribute	Description

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

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

7.7.3 Describe any requirements you may have for your contracted hospitals to report performance information based on the National Quality Forum consensus measures. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69376

7.7.4 Describe your measurement strategy for the following areas:

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

7.7.5 For your networks, describe how you support the following:

Attribute	Description

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

7.8 INNOVATIONS

7.8.1 Describe your institutional capacity to plan, implement, and evaluate future healthcare quality and cost innovations for Exchange Members.

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

To facilitate analytics and innovations based on data, Contracted QHP will submit claims and encounter data to an Exchange identified third party analytics vendor. Vendor will aggregate data elements related to the following areas:

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

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

☐ Yes

☐ No

8. eVALUE8™ SUBMISSION

8.1 BUSINESS PROFILE

8.1.1 Instructions

8.1.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

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

8.1.1.3 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. The PPO question always follows the HMO question. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question below in 1.1.5.

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

8.1.1.5 Plan is responding for the following products

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

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

Single, Radio group.
1: HMO/POS,
2: PPO

8.1.2 Contact and Organization Information

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

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

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

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

8.1.2.3 Tax Status

Single, Pull-down list.
1: Profit,
2: Non-Profit

8.1.2.4 Did ownership change in 2013 or is a change being considered in 2014?

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

8.1.3 Market Position

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

8.1.3.2 Identify the Plan membership in each of the products specified below **within the response market as of 12/31/13**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers. Please copy this response into the following questions 8.1.3.3 and 8.1.3.4.

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

8.1.3.3 Identify the Plan membership in each of the products specified below **for the state of California as of 12/31/13**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers across the country.

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

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

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

8.1.3.4 Identify the Plan membership in each of the products specified below **nationally as of 12/31/13**. Enter 0 if product not offered. Please provide an answer **for all products** the Plan offers.

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

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

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

8.1.4 Accreditation and CAHPS Performance

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

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

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA MCO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4. Provisional 5. Interim 6. Denied 7: NCQA not used or product not eligible	*To the day.* From Dec 30, 1972 to Dec 31, 2022.	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application. 2: Interim. 3. First 4. Renewal	*To the day.* From Dec 30, 1972 to Dec 31, 2022.	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.* From Dec 30, 1972 to Dec 31, 2022.	*Unlimited.*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.* From Dec 30, 1972 to Dec 31, 2022.	*Unlimited.*

NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.* From Dec 30, 1972 to Dec 31, 2022.	*Unlimited.*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.* From Dec 30, 1971 to Dec 31, 2022.	
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From Dec 31, 1972 to Jan 01, 2023.	
URAC Accreditation - Comprehensive Wellness	AS ABOVE	AS ABOVE	
URAC Accreditations - Disease Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Health Utilization Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Case Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Pharmacy Benefit Management	AS ABOVE	AS ABOVE	

8.1.4.2 PPO version of above.

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

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

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

Please refer to the attached document for an explanation of terms

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

	HMO QC 2013	HMO QC 2012
Rating of Health Plan (9+10)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Rating of All Health Care (9+10)	AS ABOVE	AS ABOVE

8.1.4.4 PPO version of above.

8.1.5 Business Practices and Results

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

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

	Data proactively collected from all new enrollees (specify date started - MM/DD/YYYY)	How data is captured from previously enrolled members(i.e., those who were not new enrollees when respondent started collecting information) - specify method	Members captured as percent of total commercial population (statewide)
Race/ethnicity	*To the day.* N/A OK.	*Multi, Checkboxes.* 1: Enrollment form, 2: Health Assessment, 3: Information requested upon Website registration, 4: Inquiry upon call to Customer Service, 5: Inquiry upon call to Clinical Service line, 6: Imputed method such as zip code or surname analysis, 7: Other (specify in detail box below. 200 word limit), 8: Data not collected	*Percent.*
Primary language	*To the day.* N/A OK.	AS ABOVE	*Percent.*
Interpreter need	*To the day.* N/A OK.	AS ABOVE	*Percent.*
Education level	*To the day.* N/A OK.	AS ABOVE	*Percent.*

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

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

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

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

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

Condition-specific information feed (e.g., phone text health reminders)	AS ABOVE			AS ABOVE
Other (describe below)	AS ABOVE			AS ABOVE

8.1.6 Collaborative Practices

8.1.6.1 Is the Plan engaged in any of the following nationally organized programs in the market of this RFI response? Identify other markets of engagement. List any ACO contracts that became effective in this market on 1/1/2014 in other information section at end of this module

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

	Engaged in any market/region	Engaged in this market	Other markets in which engaged
The Plan is not engaged in any of the below programs	*Multi, Checkboxes - optional.* 1: Not Engaged in Any Programs		
Leapfrog Hospital Rewards Program	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Prometheus	AS ABOVE	AS ABOVE	AS ABOVE
Bridges to Excellence	AS ABOVE	AS ABOVE	AS ABOVE
Aligning Forces for Quality	AS ABOVE	AS ABOVE	AS ABOVE
Chartered Value Exchange	AS ABOVE	AS ABOVE	AS ABOVE
Health Map RX (Asheville Project)	AS ABOVE	AS ABOVE	AS ABOVE
Multi-payer Medical Home (name additional payers in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Accountable care organizations (name groups and hospitals under contract in response market in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Purchaser-organized programs (e.g., Xerox in Rochester, NY) described in detail box	AS ABOVE	AS ABOVE	AS ABOVE
California Hospital Assessment and Reporting Taskforce (CHART)	AS ABOVE	AS ABOVE	AS ABOVE
California Health Performance Information System (CHPI)	AS ABOVE	AS ABOVE	AS ABOVE
Integrated Healthcare Association (IHA) Pay for Performance Program	AS ABOVE	AS ABOVE	AS ABOVE
IHA Division of Financial Responsibility (DOFR) (Describe in detail box your organization's current use, if any, of DOFRs with providers. If applicable, identify the percentage of providers utilizing DOFRs and describe any plans to increase usage.)	AS ABOVE	AS ABOVE	AS ABOVE
Other (described in detail box)	AS ABOVE	AS ABOVE	AS ABOVE

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

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

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

•implement performance measurement at the physician and other clinician or group level;

•collect and aggregate data in the most appropriate way; and

•report meaningful information to consumers, physicians and other clinicians, and other stakeholders to inform decision-making and improve outcomes

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

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

The Leapfrog Group includes private and public health care purchasers that provide health benefits to more than 34 million Americans and spend more than $60 billion on health care annually. Information on the four Leapfrog safety practices (CPOE, Evidence-Based Hospital Referral, ICU Physician Staffing, NQF-endorsed Safe Practices) is available at http://www.leapfroggroup.org/for_hospitals/leapfrog_hospital_survey_copy/leapfrog_safety_practices. Name participants for each collaboration.

Agreement must be in place by time of submission for credit to be awarded. ***If activity has been implemented based on agreement, respond in agreement row and note the implementation date in last column.***

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

8.1.7 Other Information

8.1.7.1 If the Plan would like to provide additional information about Plan Profile that was not reflected in this section, provide as Profile 3. **List any ACO contracts that became effective in this market on 1/1/2014.**

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

8.2 Physician and Hospital (Provider) Management and Measurement

8.2.1 Instructions and Definitions

8.2.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

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

8.2.1.3 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5.

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

8.2.2 Management and Contracting

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

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

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

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

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

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

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

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

8.2.2.3 On behalf of Purchasers and to reduce response burden, NBCH and the Catalyst for Payment Reform (CPR) are collaborating on a set of questions to collect and report plan responses with respect to payment reform. This set of questions is flagged as CPR. A subset of questions (2.2.4, 2.8.1, 2.8.4, 2.8.6, 2.11.2, 2.10.1, 2.10.2, 2.10.5) replaced other payment reform questions that were posed in eValue8 2012. The goal of this set of questions on payment reform is to inform and track the nation's progress on payment reform initiatives. CPR received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses to questions. Information on the National Scorecard and Compendium such as a FAQ and methodology can be found at http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard. Results of the responses for the National Scorecard are displayed in the aggregate (i.e., health plans will not be identified and there will be no plan-to-plan comparison). See example from last year's response http://www.catalyzepaymentreform.org/images/documents/NationalScorecard.pdf.

The goal of this question is to establish the context as well as establish the denominators for other questions in this module. NOTE: This question asks about **total** dollars ($) paid for PUBLIC as well as PRIVATE programs in **calendar year (CY) 2013**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2013, Plans may elect to report on the most recent 12 months with sufficient information and note the time period in the detail box below. If this election is made, ALL answers on CPR payment dollar questions (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2 , 2.11.4 and 2.10.5) for CY 2013 should reflect the adjusted reporting period.**

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

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

- Some of the questions, such as "Provide the total in-network dollars paid to providers for commercial members CY 2013," apply to multiple metrics and will inform multiple denominators. Accordingly, this question is only posed once but the answer will be used to calculate all relevant metrics.

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

Detail Box: Note the 12 month time period used by respondent for all payment reform questions if time period is NOT the requested CY 2013. Also explain differences (IF ANY) in total $ in row 5 columns 1 and 3.

	Total $ Paid in Calendar Year (CY) 2013 or the most current 12 months with sufficient dollar information	Calculated percent Numerator = # in specific row Denominator for rows 1 to 5= Total in Row 6	Description of metric	Row Number
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for FULLY-INSURED commercial members	*Decimal.* From 0 to 100000000000.	*For comparison.* Unknown	**Health Plan Dollars - Fully-Insured Commercial In-Network:** Total in-network dollars paid to providers for fully-insured commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	1
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for SELF-INSURED commercial members	*Decimal.* From 0 to 100000000000.	*For comparison.* Unknown	**Health Plan Dollars - Self-Funded Commercial In-Network:** Total in-network dollars paid to providers for self-funded commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	2
Total OUT-OF-NETWORK dollars paid to ALL providers (including hospitals) for ALL (fully-insured and self-insured) commercial members	*Decimal.* From 0 to 100000000000.	*For comparison.* Unknown	**Health Plan Dollars - Commercial Out-of-Network:** Total out-of-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	3
Total dollars paid to ALL providers for public programs (involving non-commercial members)	*Decimal.* From 0 to 100000000000.	*For comparison.* Unknown	**Health Plan Dollars - Public Programs:** Total dollars paid to providers for public programs as a percent of total dollars paid to ALL providers for ALL lines of business	4
Calculated: Total IN-NETWORK dollars paid to ALL providers (including hospitals) for ALL commercial members.(sum of rows 1 and 2)	*For comparison.* 0	*For comparison.* Unknown	**Health Plan Dollars - Total Commercial In-Network:** Total in-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business. This is the denominator used for autocalc in rows 7 & 8 The sum of dollars reported for "all outpatient services" in Row 1 column 1 of 2.8.4 and "all hospital services" in Row 1 Column 1 of 2.10.2 is 0.	5
Calculated: Total dollars paid to all providers for all lines of business (sum of rows 3, 4 and 5)	*For comparison.* 0	*For comparison.* Unknown	Denominator for rows 1 to 5	6
Provide the total IN-NETWORK COMMERCIAL dollars	*Decimal.*	*For*	**Steps to Payment**	7

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

8.2.3 Information to Physicians to Help Steer Members

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

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

8.2.3.2 How does the Plan PROMOTE the availability and encourage use of hospital performance data by physicians?

Note that responses to this question need to be supported by attachments (e.g., if plan selects response option #2 – plan needs to attach a sample of the targeted communication to the physician).

If Plan supports a portal that is accessed by members, physicians and brokers and has no physician only portal, acceptable to select response option # 3.

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

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

Single, Pull-down list.
1: Provider 2 provided,
2: Not provided

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

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

8.2.3.5 Choosing Wisely is part of a multi-year effort of the ABIM Foundation to help physicians be better stewards of finite health care resources. Originally conceived and piloted by the National Physicians Alliance through a Putting the Charter into Practice grant, nine medical specialty organizations, along with Consumer Reports and employer coalitions, have identified five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx. A subset of the identified services is listed below. Indicate if the Plan can track incidence of the procedures listed below and whether treatment decision support or member education are provided. Do not select member education unless the communication is specific to the Choosing Wisely procedure described (and not general information about the condition).

Choosing Wisely procedure	Plan activities	Rate/1000 members	Description of other
Imaging for low back pain within the first six weeks, unless red flags are present	*Multi, Checkboxes.* 1: Plan can report incidence of procedure, 2: Plan provides treatment decision support to member, 3: Plan provides member education about this procedure, 4: Other (describe), 5: None of the above	*Decimal.*	*50 words.*
Brain imaging studies (CT or MRI) in the evaluation of simple syncope and a normal neurological examination.	AS ABOVE	AS ABOVE	AS ABOVE
Repeat Abdominal CT for functional abdominal pain	AS ABOVE	AS ABOVE	AS ABOVE
Use of dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors	AS ABOVE	AS ABOVE	AS ABOVE
Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms	AS ABOVE	AS ABOVE	AS ABOVE
Stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present	AS ABOVE	AS ABOVE	AS ABOVE
Annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients	AS ABOVE	AS ABOVE	AS ABOVE
Stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery	AS ABOVE	AS ABOVE	AS ABOVE
Echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms	AS ABOVE	AS ABOVE	AS ABOVE
Stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI)	AS ABOVE	AS ABOVE	AS ABOVE

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

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

	Type of Monitoring	Detail
Screening adults for tobacco use at every medical encounter	*Multi, Checkboxes.* 1: Chart audit, 2: Electronic Medical Records, 3: Survey/Self report,	*65 words.*

	4: Other monitoring method (Describe in detail box), 5: This screening is recommended, but not monitored, 6: This screening is not recommended	

8.2.4.2 Identify Plan activities in calendar year 2013 for practitioner education and support related to tobacco cessation. Check all that apply. If any of the following four (4) activities are selected, documentation to support must be attached in the following question as Provider 3. The following selections need documentation:

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

	Activities
Education/Information	*Multi, Checkboxes.* 1: General education of guidelines and health plan program offerings, 2: Notification of member identification, 3: CME credit for smoking cessation education, 4: Comparative performance reports (identification, referral, quit rates, etc.), 5: Promotion of the appropriate smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 9402, and HCPCS G0375, G0376) (describe), 6: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of member materials for provider use and dissemination, 2: Member-specific reports or reminders to screen, 3: Member-specific reports or reminders to treat (smoking status already known), 4: Routine progress updates on members in outbound telephone management program, 5: None of the above
Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Plan reimburses for appropriate use of smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 99402, and HCPCS G0375, G0376), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice support	*Multi, Checkboxes.* 1: The plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports, 5: Care plan approval, 6: None of the above
Description	*200 words.*

8.2.4.3 If plan selected response options 1 and 4 in education/information and options 2 and 3 in patient support in question above, provide evidence of practitioner support as Provider 3. Only include the minimum documentation necessary to demonstrate the activity. A maximum of one page per activity will be allowed.

Multi, Checkboxes.
1: General communication to providers announcing resources/programs available for tobacco cessation (3a),
2: Comparative reporting (3b),
3: Member specific reminders to screen (3c),
4: Member specific reminders to treat (3d),
5: Provider 3 not provided

8.2.4.4 Identify Plan activities in calendar year 2013 for practitioner education and support related to obesity management. Check all that apply. If any of the following four (4) activities are selected, documentation must be provided as Provider 4 in the following question:

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

	Activities
Education/Information	*Multi, Checkboxes.* 1: General education of guidelines and health plan program offerings, 2: Educate providers about screening for obesity in children, 3: Notification of member identification, 4: CME credit for obesity management education, 5: Comparative performance reports (identification, referral, quit rates, etc.), 6: Promotes use of Obesity ICD-9 coding (e.g. 278.0) (describe), 7: Distribution of BMI calculator to physicians, 8: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of materials/education/information therapy for provision to members, 2: Member-specific reports or reminders to screen,

	3: Member-specific reports or reminders to treat (obesity status already known), 4: Periodic reports on members enrolled in support programs, 5: None of the above
Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Plan reimburses for appropriate use of Obesity ICD-9 coding (e.g. 278.0), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice Support	*Multi, Checkboxes.* 1: The plan provides care managers and/or behavioral health practitioners who can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports, 5: Care plan approval, 6: None of the above
Description	*200 words.*

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

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

8.2.5 Scope of Physician Measurement for Transparency and Rewards

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

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

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

One approach to meeting the Consumer -Purchaser Alliance (formerly known as the Consumer-Purchaser Disclosure Project) "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (available at http://healthcaredisclosure.org/docs/files/PatientCharter.pdf) is meeting the measurement criteria specified in the NCQA Physician and Hospital Quality Standards (available at http://www.ncqa.org).

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

Total $ value of claims paid to all Specialty physicians in network	*Dollars.*	
Total $ value of claims paid those Specialty physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Dollars.* N/A OK. From 0 to 100000000000.	*For comparison.* 0.00%

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

8.2.6.1 Purchasers are under significant pressure to address the dual goals of ensuring employees access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems. These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, narrow/tiered performance-based networks and reference pricing, among others.

For your entire commercial book of business, describe below any current payment approaches for physician (primary care and or specialty) outpatient services that align financial incentives with reducing waste and/or improving quality or efficiency. ***Please refer to response in question 2.8.4 and the attached definitions document.***

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

If plan does not have any programs in market of response, please provide information on a program in the closest market to market of response, and also provide information on any programs you plan to implement in market of response within the next 6 months.

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

This question replaces 3.4.1 and section 3.10 from eValue8 2012.

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

Email for person authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact email for the payment reform program, please reenter his/her email)	*5 words.*	N/A	N/A	7
Geography of named payment reform program (Ctrl-Click for multiple states)	*Single, Radio group.* 1: Not in this market (Identify market in column to the right), 2: In this market and other markets (Identify market(s) in column to the right), 3: Only in this market	*Multi, List box.* 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc. (all states)		8
Summary/Brief description of Program (500 words or less)	*500 words.*	N/A		9
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*		10
What is current stage of implementation? Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the day.*		11
To which payment reform model does your program most closely align? For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program, or is the most dominant payment reform model of those that are used in the program.	*Single, Radio group.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with HACs (healthcare acquired conditions also known as hospital-acquired conditions) that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	*65 words.*		12
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled or episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8: Other - (provide details in next column)	*50 words.*		13
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) – describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*50 words.*		14
If you have a payment reform model that includes policies on non-payment for specific services associated with complications that were preventable or services that were unnecessary, for which outcomes are these policies in place?	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions, 3: Healthcare acquired conditions (HACs) also known as hospital-acquired conditions, 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)	*65 words.*	*65 words.*	15
Which of the following sets of performance measures does your program use?	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use,	*50 words.*	*50 words.*	16

	10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)			
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to support the payment reform program.	*Multi, Checkboxes.* 1: Mandatory use of Centers of Excellence (COE) or higher performing providers, 2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers, 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 4: Use of tiered/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: Other (please describe)	*50 words.*	*50 words.*	17
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or efficiency measures at the provider level?	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*50 words.*	*50 words.*	18
Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*100 words.*	*100 words.*	19
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X			20

8.2.6.2 For HMO, indicate if payment rewards for physician (primary care and/or specialty) quality performance is assessed and used for any of the following categories of PQRS Measure Groups and other measures. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars). Please see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

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

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in network – please insert this number in appropriate column - newly created last column

Only one of the last two columns needs a %response – system will not allow plan to save responses if both of the last 2 columns have responses

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf and "Advancing Physician Performance Measurement: Using Administrative Data to Assess Physician Quality and Efficiency" available at http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

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

Category of PQRS Measure & Other Measures	Level/system at which reward is assessed/ paid (HMO)	Indicate if rewards available to primary care and/or specialty physicians (HMO)	Description of Other (HMO)	(preferred) % total contracted physicians in market receiving reward (Denominator = all PCPs and relevant specialists) (HMO)	(Alternate)% total contracted physicians in market receiving reward (Denominator = all PCPs and all specialists in network) (HMO)
Diabetes Mellitus	*Multi, Checkboxes.* 1: Individual Physician, 2: Practice Site, 3: Medical	*Multi, Checkboxes.* 1: Primary care, 2: Specialty	*50 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.

	Group/IPA/Staff model Group, 4: PCMH, 5: ACO, 6: Other (describe), 7: None of the above				
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention)	AS ABOVE	AS ABOVE			
Coronary Artery Bypass Graft	AS ABOVE	AS ABOVE			
Perioperative Care	AS ABOVE	AS ABOVE			
Back pain	AS ABOVE	AS ABOVE			
Coronary Artery Disease	AS ABOVE	AS ABOVE			
Heart Failure	AS ABOVE	AS ABOVE			
Community-Acquired Pneumonia	AS ABOVE	AS ABOVE			
Asthma	AS ABOVE	AS ABOVE			
NCQA Recognition program certification	AS ABOVE	AS ABOVE			
Patient experience survey data (e.g., A-CAHPS)	AS ABOVE	AS ABOVE			
Mortality or complication rates where applicable	AS ABOVE	AS ABOVE			
Efficiency (resource use not unit cost)	AS ABOVE	AS ABOVE			
Pharmacy management (e.g. generic use rate, formulary compliance)	AS ABOVE	AS ABOVE			
Medication Safety	AS ABOVE	AS ABOVE			
Health IT adoption/use	AS ABOVE	AS ABOVE			
Preventable Readmissions	AS ABOVE	AS ABOVE			
Preventable ED/ER visits (NYU)	AS ABOVE	AS ABOVE			

8.2.6.3 PPO version of above

8.2.6.4 This and questions 2.8.6 and 2.10.2 define the characteristics of the Payment Reform Environment of the CPR Scorecard (Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members) for all primary care and specialty OUTPATIENT SERVICES (i.e., services for which there is N O ASSOCIATED HOSPITAL CHARGE) and replaces **3.5.3 and 3.5.4 from eValue8 2012.** ***The corresponding question for hospital services is 2.10.2 THE SUM of the Number in Row 1 column 1 for outpatient and hospital services (2.8.4 and 2.10.2) should EQUAL ROW 5 in Question 2.2.4 above***

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

NOTE: This question asks about total $ paid in **calendar year (CY) 2013**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2013, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2 , 2.11.4 and 2.10.5) for CY 2013 should reflect the adjusted reporting period.**

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

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

HELPFUL TIPS: To determine the most appropriate payment category to which dollars from your payment reform program(s) should be allocated, please use the following steps:

1. *Determine if the base payment of the program is fee-for-service (FFS) or not. If it is NOT based on FFS, ensure that the program category you select has "non-FFS based" in the program category.*
2. *Determine if the payment for the program has a quality component or is tied to quality in some way (rather than just tied to efficiency). If the payment reform program does include a quality component, for example, please ensure that the program category you select has "with quality" in the program category.*
3. *Identify the **dominant** payment reform mechanism for a given payment reform program.*
4. *For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program (e.g., if your program pays providers based upon thresholds for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).*

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

ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	**ALL Providers for Outpatient Services** (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) Total $ Paid in Calendar Year (CY) 2013 or most current 12 months (Estimate breakout of amount in this column into percentage by entity paid in next 3 columns)	**Primary Care physicians** paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	**Specialists (including Ob-GYNs)** paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	**Contracted entities** (e.g., ACOs/PCMH/ Medical Groups/IPAs) paid under listed payment category below *(Estimated Percentage of dollar amount listed in column 1 for each row)*	*This column activated only if there is % listed in column 4 (preceding column) Please select which contracted entities are paid*	**Autocalculated percent** based on responses in column 1. Denominator = total $ in row 1 column 1 Numerator = $ in specific row C1	Row Number
Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	*Dollars.*	*Percent.*	*Percent.*	*Percent.*	*Multi, Checkboxes.* 1: ACO, 2: PCMH, 3: Medical Groups/IPAs	*For comparison.* Unknown Note: Percentages provided in this row do not total 100%	1
Provide the total dollars paid to providers through traditional	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	2

FFS payments in CY 2013 or most recent 12 months							
Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	3
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	4
Provide the total dollars paid to providers through fully capitated programs without quality in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	5
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2013 for primary care and specialty outpatient services (i.e., services for which there	*For comparison.* $0.00	*Percent.*	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	6

is NO ASSOCIATED HOSPITAL CHARGE) [Sum of Rows 2, 3 4 and 5]							
Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	7
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	8
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	9
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	10
Provide the total dollars	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	11

paid to providers through fully capitated payment with quality components in CY 2013 or most recent 12 months.	From 0 to 10000000000000000.						
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	12
Provide the total dollars paid to providers through bundled payment programs with quality components CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	13
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	14
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	15
Provide the	*Dollars.*	*Percent.*	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	16

total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***	N/A OK. From 0 to 10000000000000000.	N/A OK.	N/A OK.	N/A OK.			
Total dollars paid to payment reform programs based on FFS.	*For comparison.* $0.00	*Percent.*	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	17
Total dollars paid to payment reform programs NOT based on FFS.	*For comparison.* $0.00	*Percent.*	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	18

8.2.6.5 Please review your responses to question 2.8.4 above. On an aggregate basis for the plan's book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for outpatient services (no associated hospital charges), and which payment approaches, if any, the health plan is using currently to tie payment to performance. If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not used.

	Estimate of allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other
Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)	*Percent.*	*Single, Pull-down list.* 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with healthcare acquired conditions (HACs) also known as hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	*65 words.*
Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Improvement over time of NQF-endorsed Outcomes and/or Process measures	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
PATIENT SAFETY (e.g.,	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*

Leapfrog, AHRQ, medication related safety issues)				
Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Longitudinal efficiency relative to target or peers	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Patient experience	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Health IT adoption or use	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Financial results	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Utilization results	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Pharmacy management	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
Other	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*
TOTAL	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*

8.2.6.6 For some of the information provided in 2.8.4 above, please ESTIMATE the break out as percent for primary care SERVICES and specialty SERVICES irrespective of entity that received the payment. If a specialty physician was paid for primary care services, payment $ should be counted as primary care services.

Note that the first column is autopopulated from plan response in 2.8.4

OUTPATIENT SERVICES	**ALL Providers for Outpatient Services Total $ Paid in Calendar Year (CY) 2013 or most current 12 months** (autopopulated from 2.8.4)	**Estimate of Percent of dollars paid FOR PRIMARY CARE OUTPATIENT SERVICES** ***Percent of dollar amount listed in column 1 for each row***	**Estimate of Percent of dollars paid FOR SPECIALTY OUTPATIENT SERVICES** ***Percent of dollar amount listed in column 1 for each row***
Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) [autopopulated from row 1 column 1 in 2.8.4]	0	*Percent.* N/A OK.	*Percent.* N/A OK.
Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2013 for outpatient services [autopopulated from row 6 column 1 in 2.8.4]	0	*Percent.* N/A OK.	*Percent.* N/A OK.
Total dollars paid to payment reform programs based on FFS.	0	*Percent.* N/A OK.	*Percent.* N/A OK.

[autopopulated from row 17 column 1 in 2.8.4]			
Total dollars paid to payment reform programs NOT based on FFS. [autopopulated from row 18 column 1 in 2.8.4]	0	*Percent.* N/A OK.	*Percent.* N/A OK.

8.2.7 Plan Policies on Healthcare Acquired Conditions and Never Events

8.2.7.1 Please indicate the scope AND REACH of the policy to address serious reportable events (SREs) or healthcare acquired conditions (HACs) also known as hospital-acquired conditions based on the following categories of services. **Policy must be in place as of February 28, 2014**.

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

	Response	% contracted Hospitals where Plan has implemented this POLICY as of 2/28/2014
Foreign object retained after surgery	*Single, Pull-down list.* 1: Plan has implemented Leapfrog Never Event Policy, 2: Plan has implemented a non-payment policy, 3: Plan does not have a policy/POA not tracked	*Percent.* N/A OK. From 0 to 100.
Air embolism	AS ABOVE	AS ABOVE
Blood incompatibility	AS ABOVE	AS ABOVE
Stage III and IV pressure ulcers	AS ABOVE	AS ABOVE
Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)	AS ABOVE	AS ABOVE
Catheter-Associated Urinary Tract Infection (UTI)	AS ABOVE	AS ABOVE
Vascular Catheter-Associate Infection	AS ABOVE	AS ABOVE
Manifestations of Poor Glycemic Control	AS ABOVE	AS ABOVE
Surgical Site Infection following Coronary Artery Bypass Graft (CABG) - - Mediastinitis	AS ABOVE	AS ABOVE
Surgical Site Infection Following Certain Orthopedic Procedures	AS ABOVE	AS ABOVE
Surgical Site Infection Following Bariatric Surgery for Obesity	AS ABOVE	AS ABOVE
Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures	AS ABOVE	AS ABOVE

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

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

8.2.8 Hospital Payment Programs for Value Achievement

8.2.8.1 Purchasers are under significant pressure to address the dual goals of ensuring employees access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems.

These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, narrow/tiered performance-based networks and reference pricing, among others.

Describe below any current payment approaches for **HOSPITAL services** that align financial incentives with reducing waste and/or improving quality or efficiency. ***Please refer to response in question 2.10.2 and the attached definitions document***. If there is more than one payment reform program involving outpatient services, please provide description(s) in the additional columns.

If plan does not have any programs in market of response, please provide information on a program in the closest market to market of response, and also provide information on any programs you plan to implement in market of response within the next 6 months.

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

This question replaces 3.6.1 and section 3.10 from eValue8 2012.

	Program 1	Other markets/details for Program 1	Repeat for Programs 2-5	Row Number
Name of Payment Reform Program and Name and contact details (email and phone) of contact person who can answer questions about program being described	*65 words.*	N/A	N/A	1
Contact Name for Payment Reform Program (person who can answer questions about the program being described)	*5 words.*	N/A	N/A	2
Contact Person's Title	*5 words.*	N/A	N/A	3
Contact Person's Email	*5 words.*	N/A	N/A	4
Contact Person's Phone	*5 words.*	N/A	N/A	5

Contact Name for person who is authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact name for the payment reform program, please reenter his/her name)	*5 words.*	N/A	N/A	6
Email for person authorized to update this program entry in ProposalTech after plan has submitted response (if same as contact email for the payment reform program, please reenter his/her email)	*5 words.*	N/A	N/A	7
Geography of named payment reform program (Ctrl-Click for multiple states)	*Single, Radio group.* 1: Not in this market (Identify market in column to the right), 2: In this market and other markets (Identify market(s) in column to the right), 3: Only in this market	*Multi, List box.* 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc., all states	*Multi, List box.* 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, etc., all states	8
Summary/Brief description of Program (500 words or less)	*500 words.*	N/A	N/A	9
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*	*50 words.*	10
What is current stage of implementation? Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the day.*	*To the day.*	11
To which payment reform model does your program most closely align? For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program, or is the most dominant payment reform model of those that are used in the program.	*Single, Radio group.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with HACs (healthcare acquired conditions also known as hospital-acquired conditions) that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	*65 words.*	*65 words.*	12
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled or episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8: Other - (provide details in next column)	*50 words.*	*50 words.*	13
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) – describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*50 words.*	*50 words.*	14
If you have a payment reform model that includes policies on non-payment for specific services associated with complications that were preventable or services that were unnecessary, for which outcomes are these policies in place?	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions, 3: Healthcare acquired conditions (HACs) also known as hospital-acquired conditions, 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)	*65 words.*	*65 words.*	15

Which of the following sets of performance measures does your program use?	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	*50 words.*	*50 words.*	16
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to support the payment reform program.	*Multi, Checkboxes.* 1: Mandatory use of Centers of Excellence (COE) or higher performing providers, 2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers, 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 4: Use of tiered/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: Other (please describe)	*50 words.*	*50 words.*	17
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or efficiency measures at the provider level?	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*50 words.*	*50 words.*	18
Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*100 words.*	*100 words.*	19
Do not include this information in the National Compendium on Payment Reform	*Multi, Checkboxes - optional.* 1: X			20

8.2.8.2 This and questions 2.8.4 and 2.8.6 define the characteristics of the Payment Reform Environment of the CPR Scorecard. Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members for HOSPITAL SERVICES **and replaces 3.8.1 and 3.8.2 from eValue8 2012.** ***The corresponding question for outpatient services is 2.8.4. The SUM of the Number in Row 1 column 1 for outpatient and hospital services (2.8.4 and 2.10.2) should EQUAL ROW 5 in Question 2.2.4.***

Please refer to the attached definitions document.

NOTE: This question asks about total $ paid in **calendar year (CY) 2013**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2013, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment (2.2.4, 2.7.2, 2.8.4 2.8.6 2.11.2 2.10.2 , 2.11.4 and 2.10.5) for CY 2013 should reflect the adjusted reporting period.**

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

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

HELPFUL TIPS: To determine the most appropriate payment category to which dollars from your payment reform program(s) should be allocated, please use the following steps:

1. *Determine if the base payment of the program is fee-for-service (FFS) or not. If it is NOT based on FFS, ensure that the program category you select has "non-FFS based" in the program category.*
2. *Determine if the payment for the program has a quality component or is tied to quality in some way (rather than just tied to efficiency). If the payment reform program does include a quality component, for example, please ensure that the program category you select has "with quality" in the program category.*
3. *Identify the **dominant** payment reform mechanism for a given payment reform program.*
4. *For programs that have hybrid qualities, review the list of definitions to decide which payment model best describes your program (e.g., if your program pays providers based upon thresholds for quality or cost, and also provides a PMPM to providers to facilitate care coordination, select the model through which most payment is made (in this case, pay-for-performance).*
5. *For DRGs, case rates, and per diem payments please consider those as traditional FFS payments.*

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

HOSPITAL SERVICES	**ALL Providers for HOSPITAL Services Total $ Paid in Calendar Year (CY) 2013 or most current 12 months Estimate breakout of amount in this column into percentage by contracted entity paid in next 2 columns**	**HOSPITALS paid under listed payment category below *Estimated Percentage of dollar amount listed in column 1 for each row***	**Contracted entities (e.g., ACOs/PCMH/Medical Groups/IPAs) paid under listed payment category below *Estimated Percentage of dollar amount listed in column 1 for each row***	***This column activated only if there is % listed in column 3 Please select which contracted entities are paid in column 3***	**Autocalculated percent based on responses in column 1. Denominator = total $ in row 1 column 1 Numerator = $ in specific row C1**	**Row Number**
Total IN-NETWORK dollars paid for to Providers for ALL commercial members for HOSPITAL SERVICES	*Dollars.*	*Percent.*	*Percent.*	*Multi, Checkboxes.* 1: ACO, 2: PCMH, 3: Medical Groups/IPAs, 4: Primary Care, 5: Specialists	*For comparison.* Unknown Note: Percentages provided in this row do not total 100%	1
Provide the total dollars paid to providers through traditional FFS payments in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	2
Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	3
Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	4
Provide the total dollars paid to providers through fully capitated programs without quality in CY 2013 or most recent 12 months	*Dollars.* N/A OK.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	5

Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2013 for hospital services [Sum of Rows 2, 3 4 and 5]	*For comparison.* $0.00	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	6
Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	7
Provide the total dollars paid to providers through FFS-based shared-savings programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	8
Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality components CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	9
Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	10
Provide the total dollars paid to providers through fully capitated payment with quality components in CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	11
Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	12
Provide the total dollars paid to providers through bundled payment programs with quality components CY 2013 or most recent 12 months	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	13
Provide the total dollars paid for FFS-based non-visit functions. (see definitions for examples) in CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	14
Provide the total dollars paid for non-FFS-based non-visit functions. (see definitions for examples) in CY 2013 or most recent 12 months.	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	15
Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***	*Dollars.* N/A OK. From 0 to 10000000000000000.	*Percent.* N/A OK.	*Percent.* N/A OK.	AS ABOVE	AS ABOVE	16
Total dollars paid to payment reform programs based on FFS. AUTOSUM ROWS 8, 10 and 14	*For comparison.* $0.00	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	17
Total dollars paid to payment reform programs NOT based on	*For comparison.* $0.00	*Percent.*	*Percent.*	AS ABOVE	AS ABOVE	18

FFS. AUTOSUM ROWS 7, 9, 11-13, 15 and 16						

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

Hospital Services	Estimate of Allocation of Incentive payments (see question above)	Product where incentive available	Type of Payment Approach	Description of other	Row Number
Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)	*Percent.*	*Single, Pull-down list.* 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment policy for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (describe in next column)	*65 words.*	1
Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	2
Improvement over time of NQF-endorsed Outcomes and/or Process measures	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	3
PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	4
Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	5
Longitudinal efficiency relative to target or peers	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	6
Application of specific medical home practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	7
Patient experience	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	8
Health IT adoption or use	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	9

Financial results	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	10
Utilization results	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	11
Pharmacy Management	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	12
Other	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	13
Total	*Percent.*	AS ABOVE	AS ABOVE	*65 words.*	14

8.2.8.4 For the measures used in determining financial incentives paid to **hospitals and/or physicians involving HOSPITAL SERVICES IN THIS MARKET**, indicate payment approach, system/entities paid and the percentage of the contracted entities receive payment reward. To calculate percentage, please use unduplicated count of hospitals and physicians. This is same measure set as in 4.6.2

Information on the measures is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/OutcomeMeasures.html

The AHRQ Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care.
- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures.
- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events.

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

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

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

In detail box below - please note if needed any additional information about percentages provided (e.g., if payment is made for a composite set of measures - indicate which)

	Product where incentive available	System/ Entity Paid	Type of Payment Approach	Description of Other	% network hospitals receiving reward	% network physicians receiving reward
HQA						
ACUTE MYOCARDIAL INFARCTION (AMI)	*Single, Radio group.* 1: HMO, 2: PPO, 3: Both	*Multi, Check boxes.* 1: Hospital, 2: ACO, 3: Physician or	*Multi, Checkboxes.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions,	*65 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.

	HMO and PPO, 4: Not availabl e	physician group, 4: Other	9: Non-FFS-based non-visit functions, 10: Non-payment policy for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (describe in next column)			
HEART FAILURE (HF)	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
PNEUMONIA (PNE)	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
SURGICAL INFECTION PREVENTION (SIP)	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Surgical Care Improvement Project (SCIP)	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
PATIENT EXPERIENCE/H-CAHPS	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/leapfrog_safety_practices	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Leapfrog Hospital Safety Score	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Adoption of CPOE	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Management of Patients in ICU	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Evidence-Based Hospital referral indicators	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Adoption of NQF endorsed Safe Practices	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Maternity – pre 39 week elective induction and/or elective c-section rates	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*				AS ABO VE	AS ABO VE	AS ABO VE
Inpatient quality indicators	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
Prevention quality indicators	AS ABO VE	AS ABOV E	AS ABOVE	AS ABO VE	AS ABO VE	AS ABO VE
OTHER MEASURES				AS ABO VE	AS ABO VE	AS ABO VE
HACs – hospital acquired conditions (e.g., Surgical	AS ABO	AS ABOV	AS ABOVE	AS ABO	AS ABO	AS ABO

site infection following coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	VE	E		VE	VE	VE
SREs (serious reportable events) that are not HACs (e.g., surgery on the wrong body part or wrong patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx. Please refer to attachment	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Readmissions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
ED/ER Visits	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
ICU Mortality	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
HIT adoption/use	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other standard measures endorsed by National Quality Forum (describe):	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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

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

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

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

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

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

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

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

Maternity Services Payment Reform	***Response***
Provide the total dollars paid to hospitals for maternity care in Calendar Year (CY) 2013 or most current 12 months with sufficient information	*Dollars.* N/A OK.
Provide the total dollars paid for maternity care to hospitals with contracts that include incentives to adhere to clinical guidelines, which, if followed, would reduce unnecessary elective medical intervention during labor and delivery in the past year. Such incentives can either be positive (e.g. pay for performance) or negative (disincentives), such as non-payment for care that is not evidence-based.	*Dollars.* N/A OK. From 0 to 1000000000000000000.
Autocalc: Row 2/Row 1 **Percent of total maternity care dollars paid that go to hospitals with contracts that provide incentives for adhering to clinical guidelines which, if followed, would reduce unnecessary elective interventions related to unnecessary elective medical intervention during labor and delivery in the past year.**	*For comparison.* Unknown

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

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

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

	Primary care	Specialty care
Tiered networks, PCMH or ACOs not used	*Multi, Checkboxes - optional.* 1: Not used	*Multi, Checkboxes - optional.* 1: Not used
Number of physicians in full product network	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000000.
Number of physicians in preferred tier/narrow network(exclude those in PCMHs and ACOs)	AS ABOVE	AS ABOVE
Percent of network physicians in preferred tier/narrow network	*For comparison.* N/A%	*For comparison.* N/A%
Number of physicians in PCMH only (exclude those in ACOs)	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000.
Percent of network physicians in PCMH	*For comparison.* N/A%	*For comparison.* N/A%
Number of physicians in ACOs	*Decimal.* N/A OK. From 0 to 10000000000.	*Decimal.* N/A OK. From 0 to 10000000000.
Percent of network physicians in ACOs	*For comparison.* N/A%	*For comparison.* N/A%
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (prior 12 months)	*Percent.* N/A OK.	*Percent.* N/A OK.

Percent of total physician payments made to PCMHs (not to those in ACOs) (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.
Percent of total physician payments made to physicians in the ACO (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.
Design incentives - HMO	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable
Design incentives - PPO	AS ABOVE	AS ABOVE
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing physicians in calendar year 2013. This could include (1) reduction in costs, (2) change in amount paid to higher performing physicians or (3) change in percent of membership using higher performing physicians	*100 words.*	*100 words.*

8.2.9.2 Payment Reform Penetration - Plan Members: For those providers that participated in a payment reform contract in CY 2013 (or the time period used by respondent for the previous questions) provide an estimate of the percent of commercial, in-network plan members attributed to those providers.

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

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

8.2.9.3 For commercial book of business, provide the requested information on the Plans in-network general acute care hospitals in the geographic region of this RFI response based on reports to the Leapfrog survey in 2011 and 2012. Multi-market plans should provide their statewide response in the column "For multimarket plans, and also indicate 2012 statewide percentages."

The 2012 “Leapfrog’s Health Plan Performance Dashboard,” shows what percentage of a plan’s admissions have been at hospitals that report to Leapfrog and what percentage of their admission use hospitals that score in the highest “quadrant” based on both their quality and resource use scores.

Use this link for the 2012 HPUG dashboard: www.leapfroggroup.org/healthplanusersgroup

For 2011 data, plans should use what they submitted last year. Plans who did not respond last year should select the NA box.

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

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

	2012	For multimarket plans, also indicate 2012 statewide percentages	2011
Percent of contracted hospitals reporting in this region	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.
Percent of Plan admissions to hospitals reporting to Leapfrog	AS ABOVE	AS ABOVE	*Percent.* N/A OK.
Leapfrog Performance Dashboard % admissions in Quadrant I	AS ABOVE	AS ABOVE	*Percent.* N/A OK.
Leapfrog Performance Dashboard % admissions in Quadrant III	AS ABOVE	AS ABOVE	*Percent.* N/A OK.

8.2.9.4 For total commercial book of business, if the Plan differentiates its contracted hospitals via tiered networks or other plan design that provide financial incentives to "steer" consumers to a subset of higher performing providers, please complete the following table.

	Hospitals
Tiered networks/ACOs used	*Single, Radio group.* 1: Yes, 2: No
Number of hospitals in full product network	*Decimal.* From 0 to 10000000000.
Number of network hospitals in preferred tier/narrow network (not in ACO)	*Decimal.* N/A OK. From 0 to 10000000000.
Number of network hospitals in ACOs	*Decimal.* N/A OK. From 0 to 10000000000.
Percent of network hospitals in preferred tier/narrow network (not in ACO)	Unknown
Percent of network hospitals in ACOs	Unknown
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (prior 12 months)	*Percent.* N/A OK. From 0 to 100.
Percent of total hospital payments made to hospitals in ACOs (most recent 12 months)	*Percent.* N/A OK. From 0 to 100.
Design incentives (HMO)	*Multi, Checkboxes.* 1: differential copay, 2: differential coinsurance, 3: differential deductible, 4: lower premium (narrow network), 5: none of the above
Design incentives (PPO)	*Multi, Checkboxes.* 1: differential copay, 2: differential coinsurance, 3: differential deductible, 4: lower premium (narrow network), 5: none of the above
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing hospitals) in calendar year 2013. This could include (1) reduction in costs, (2) change in amount paid to higher performing hospitals or (3) change in percent of membership using higher performing hospitals	*100 words.*

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

HMO response	Selection Criteria	Steerage Results 2013	Quality and Cost Impact (2013)	Steerage Results 2012
Bariatric Surgery	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	*Percent.* N/A OK.	*Unlimited.*	*Percent.* N/A OK.
Cancer Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Cardiac Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Neonatal Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Transplants	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.2.9.6 PPO version of question.

8.2.10 Hospital Management Performance

8.2.10.1 Reducing readmissions is an area of great interest to purchasers and payers as it impacts employee/member health and reduces costs in the system. In 2012, NCQA introduced the Plan All Cause Readmissions (PCR) measure which is the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older.

In the table below, please **review** the following information based on plan HMO submission to NCQA.

This answer is supplied by Health Benefit Exchange (individually.

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

8.2.10.2 PPO version of question

8.2.11 Other Information

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

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

8.3 HELPING MEMBERS STAY/GET HEALTHY

8.3.1 Instructions

8.3.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.

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

8.3.1.3 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

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

8.3.2 Alignment of Plan Design

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

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

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

Please respond accordingly in the last column.

HMO Response - Preventive and Wellness Services	Financial Incentives	Product availability	Uptake as % of total commercial statewide membership noted in 1.3.3	Percentage is based on plan's entire commercial membership in all markets of plan operation
A: Incentives contingent upon member behavior				
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*

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

8.3.2.2 PPO version of question above.

8.3.3 Health Assessments (HA)

8.3.3.1 Indicate activities and capabilities supporting the plan's HA programming. Check all that apply.

Multi, Checkboxes.
1: HA Accessibility: BOTH online and in print,
2: HA Accessibility: IVR (interactive voice recognition system),
3: HA Accessibility: Telephone interview with live person,
4: HA Accessibility: Multiple language offerings,
5: Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to member based on member-specific risk, e.g. at point of “smoking-yes” response, tobacco cessation education is provided as pop-up.,
6: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses,
7: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion.,
8: Addressing At-risk Behaviors: Ongoing push messaging for self-care based on member's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member).,
9: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses,
10: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results,
11: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician,
12: Addressing At-risk Behaviors: Member can update responses and track against previous responses,

13: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results,
14: Partnering with Employers: Plan can import data from employer-contracted HA vendor.,
15: Plan does not offer an HA

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

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

HMO Response	Answer
Geography reported below for HA completion Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, including this state/region (and this state/region response provided below), 2: Participation tracked statewide and for some regions but not this region/state (and statewide response provided below), 3: Participation only tracked statewide (statewide data provided below), 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison.* TBD
Number of members completing Plan-based PHA in 2013 for regional or statewide geography as checked above.	*Decimal.* From 0 to 10000000000000000000.
Number of members completing an employer-based vendor PHA in 2013, for regional or statewide geography as checked above.	*Decimal.* N/A OK. From 0 to 100000000000.
Percent PHA completion regionally or statewide as indicated above (Plan PHA completion number + employer PHA completion number divided by total enrollment)	*For comparison.* Unknown

8.3.3.3 PPO version of question above.

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

HMO Response	Answer	Description
HA promoted	*Single, Radio group.* 1: Yes, using at least one of the following methods, 2: Yes, but not using any of the following methods below (describe), 3: No	*100 words.*
General messaging on Plan website or member newsletter	*Multi, Checkboxes.* 1: 1-2 X per year, 2: 3-6 X per year, 3: > 6 X per year, 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results. This was formerly referred to as Health Risk Assessment (HRA).	*Single, Radio group.* 1: Yes, 2: No	*100 words.* Nothing required
Financial incentives from Plan to members (describe): (FOR FULLY INSURED PRODUCTS ONLY)	*Single, Radio group.* 1: Yes, 2: No, 3: Not applicable	*100 words.* Nothing required
Financial incentives from Plan to employers (describe): (FOR FULLY INSURED PRODUCTS ONLY)	*Single, Radio group.* 1: Yes, 2: No, 3: Not applicable	*100 words.* Nothing required
Promoting use of incentives and working with Purchasers to implement	*Single, Radio group.* 1: Yes, 2: No,	*100 words.* Nothing

financial incentives for employees (describe):	3: Not applicable	required
Multiple links (3 or more access opportunities) to HA within Plan website (indicate the number of unique links to the HA). Documentation needed, provide in 3.3.7	*Decimal.* N/A OK. From 0 to 100000000000000000.	
Promotion through provider (describe):	*Single, Radio group.* 1: Yes, 2: No	*100 words.* Nothing required
Promotion through health coaches or case managers (describe):	*Single, Radio group.* 1: Yes, 2: No	*100 words.* Nothing required

8.3.3.5 PPO version of question above.

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

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

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

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

8.3.3.8 PPO version of above.

8.3.4 Cancer Screening Programs and Results

8.3.4.1 Review the two most recently calculated years of HEDIS results for the HMO Plan (QC 2013 and 2012). The HEDIS measure eligible for rotation for QC 2013 is Colorectal Cancer Screening.

If plan rotated Colorectal Cancer Screening in QC 2013, QC 2013 would be based on QC 2012, so the prior year data that would be uploaded would be QC 2011.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have

codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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

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

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

	QC 2013	QC 2012, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	AS ABOVE	AS ABOVE
Colorectal Cancer Screening (Eligible for rotation in QC 2013)	AS ABOVE	AS ABOVE

8.3.4.2 PPO version of above.

8.3.4.3 Which of the following member interventions applying to at least 75% of your enrolled membership were used by the Plan in calendar year 2013 to improve cancer screening rates? Indicate all that apply.

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

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

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

8.3.5 Immunization Programs

8.3.5.1 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2013 and QC 2012) results for the HMO Plan.

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

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

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

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

	QC 2013, or most current year's HMO result	QC 2012, or prior year's HMO QC result
Childhood Immunization Status - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combination	AS ABOVE	AS ABOVE
CAHPS Flu Shots for Adults (50-64) (report rolling average)	AS ABOVE	AS ABOVE

8.3.5.2 PPO version of above.

8.3.5.3 Identify member interventions used in calendar year 2013 to improve immunization rates. Check all that apply.

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

8.3.6 Health Promotion Programs and Worksite Wellness

8.3.6.1 For your commercial book of business, identify the programs or materials that are offered in this market to support health and wellness for all commercial members, excluding the Plan's own employees in calendar year 2013. **If programs are also available onsite, but are not offered as a standard benefit for all members, please indicate the minimum number of health plan members required to receive the service at no additional charge**.

Requirements that include the term "targeted" when referencing information or education should be consistent with threshold criteria for Information Therapy ("Ix"). Requirements for being classified as Ix include: 1. Being targeted to one or more of the individual's current moments in care. 2. Be proactively provided/prescribed to the individual. 3. Support one of more of the following: informed decision making, and/or skill building and motivation for effective self-care and healthy behaviors to the moment in care, and/or patient comfort/acceptance. 4. Be tailored to an individual's specific needs and/or characteristics, including their health literacy and numeracy levels. 5. Be accurate, comprehensive, and easy to use.

Inbound Telephone Coaching means a member enrolled in a Chronic Condition Management (CCM) Program has the ability to call and speak with a health coach at any time and support is on-going as long as the member remains in the DM/CCM program. Nurseline support is offered as a benefit to the general membership and is often a one-time interaction with a member seeking advice.

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

	4: Employer Option to buy for self-insured lives, 5: Service/program not available	
Customized printed materials for employer use that include content about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with $0 cost share under the ACA and other Employer plan designs	AS ABOVE	AS ABOVE
On-site bio-metric screenings (blood pressure, lab tests, bone density, body fat analysis, etc)	AS ABOVE	AS ABOVE
Nutrition classes/program	AS ABOVE	AS ABOVE
Fitness classes/program	AS ABOVE	AS ABOVE
Weight loss classes/program	AS ABOVE	AS ABOVE
Weight management program	AS ABOVE	AS ABOVE
Smoking cessation support program	AS ABOVE	AS ABOVE
24/7 telephonic nurse line	AS ABOVE	AS ABOVE
Inbound telephonic health coaching	AS ABOVE	AS ABOVE
Outbound telephone health coaching (personal outreach and coaching involving live interaction with a person)	AS ABOVE	AS ABOVE
Member care/service reminders (IVR)	AS ABOVE	AS ABOVE
Member care/service reminders (Paper)	AS ABOVE	AS ABOVE
Targeted personal Health Assessment (HA) formerly known as health risk assessment (HRA)	AS ABOVE	AS ABOVE
In-person lectures or classes	AS ABOVE	AS ABOVE
Social Networks for group-based health management activities, defined as online communities of people who voluntarily share health information or exchange commentary based on a common health issue or interests (e.g., managing diabetes, weight loss, or smoking cessation)	AS ABOVE	AS ABOVE
Access to PCMH and/or ACO Providers	AS ABOVE	AS ABOVE

8.3.7 Prevention and Treatment of Tobacco Use

8.3.7.1 Indicate the number and percent of tobacco dependent commercial members identified and participating in cessation activities during 2013. **Please provide state or regional counts if available.** If regional counts are not available, provide statewide counts.

	Answer
Indicate ability to track identification. Regional tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, including this state/region, 2: Identification tracked statewide and for some regions but not this state/region, 3: Identification only tracked statewide, 4: Identification not tracked statewide/regionally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Regional tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, including this state/region, 2: Participation tracked statewide and for some regions but not this state/region,

	3: Participation only tracked statewide, 4: Participation not tracked statewide/regionally, 5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on responses above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) Please verify value and, if necessary, make corrections in the Profile module.	*For comparison.* TBD
Number of commercial members individually identified as tobacco dependent in 2013 as of December 2013	*Decimal.* From 0 to 1000000000.
% of members identified as tobacco dependent	*For comparison.* 0.00%
Number of members participating in smoking cessation program during 2013 as of December 2013	*Decimal.* From 0 to 1000000000.
% of identified tobacco dependent members participating in smoking cessation program (# program participants divided by # identified smokers)	*For comparison.* 0.00%

8.3.7.2 Review the HMO QC 2013 CAHPS data regarding the Plan's regional percentage of current smokers.

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

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

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

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

HMO QC CAHPS DATA	2013 CAHPS	2012 CAHPS
Percentage that are current smokers	*Percent.*	*Percent.*
Percent of current tobacco users (estimated by CAHPS) that are identified by the plan as tobacco dependent	*For comparison.* N/A%	

8.3.7.3 Review uploaded PPO QC 2013 CAHPS data regarding the Plan's regional percentage of current smokers. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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

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

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

PPO QC CAHPS DATA	2013 CAHPS	2012 CAHPS
Percentage that are current smokers	*Percent.*	*Percent.*
Percent of current tobacco users (estimated by CAHPS) that are identified by the plan as tobacco	*For comparison.*	

dependent	N/A%	

8.3.7.4 If Plan supports a Smoking Cessation Support Program, identify how pharmaceutical coverage was covered within the program in calendar year 2013. Refer to response in 3.6.1.

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

8.3.7.5 PPO version of above.

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

Identify behavioral change interventions used in the tobacco cessation program in calendar year 2013. **These questions are referencing stand-alone tobacco cessation programs**. Enter “Zero” if the intervention is not provided to members in the tobacco cessation program. Check all that apply.

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

	Availability of intervention	Cost of intervention	Number of participants in 2013 (regional preferred - refer back to 3.7.1)	Is Number of participants provided regional or national number?	Percent receiving intervention (denominator is from 3.7.1 second to last row)
Quit kit or tool kit mailed to member’s home	*Single, Pull-down list.* 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in tobacco cessation program	*Multi, Checkboxes.* 1: Included as part of tobacco cessation program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No tobacco cessation program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No tobacco cessation program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee), 6: No tobacco cessation program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No tobacco cessation program but intervention available outside of a specific program as a buy-up option for fully insured lives, 8: Not available	*Decimal.* From 0 to 10000000000000.	*Single, Radio group.* 1: Regional, 2: National	Unknown

Interactive electronic support	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online professionally facilitated group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online chat sessions non-facilitated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Telephonic counseling program	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In person classes or group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Individual in-person counseling (this does NOT include standard behavioral health therapy where addictions may be addressed)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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

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

8.3.7.8 Review the most recent HMO uploaded program results for the tobacco cessation program from QC 2013 and QC 2012.

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

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

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

Please refer to the attached document for an explanation of terms

	2013 HMO and QC 2013 results	2012 HMO and QC 2012 results	Describe measure methodology/definition (non HEDIS measures)	Not tracked
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	Health Benefit Exchange (individually). *Percent.* From -10 to 100.	Health Benefit Exchange (individually). *Percent.* From -10 to 100.		
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	AS ABOVE	AS ABOVE		

HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	AS ABOVE	AS ABOVE		
Program defined 6-month quit rate	*Percent.* From 0 to 100.	*Percent.*	*Unlimited.*	*Multi, Checkboxes - optional.* 1: Not tracked
Program defined 12-month quit rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other (describe in "describe measure...")	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.3.7.9 PPO version of above.

8.3.8 Obesity

8.3.8.1 Indicate the number of obese members identified and participating in weight management activities during 2013. Do not report general prevalence.

Please provide state or regional counts if available. If regional counts are not available, provide statewide counts.

	Answer
Indicate ability to track identification. Regional tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, including this state/region, 2: Identification tracked statewide and for some regions but not this state/region, 3: Identification only tracked statewide, 4: Identification not tracked statewide/regionally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Regional tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	AS ABOVE
Geography for data below (automatically determined based on responses above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) Please verify value and, if necessary, make corrections in the Profile module.	*For comparison.* TBD
Number of commercial plan members identified as obese in 2013 as of December 2013	*Decimal.* From 0 to 1000000000.
% of members identified as obese	*For comparison.* 0.00%
Number of commercial plan members participating in weight management program during 2013 as of December 2013	*Decimal.* From 0 to 1000000000.
% of members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*For comparison.* 0.00%

8.3.8.2 Please refer to your response in question above as this response should be consistent with geography noted in your response in 3.8.1. Please also refer to response in 3.6.1. For plan's total commercial book of business, **identify the interventions offered in calendar year 2013 as part of your weight management program (and are not limited to members seeking bariatric surgery).** Do not consider obesity-centric counseling/behavior change interventions that are associated with other disease management programming. These questions are referencing stand-alone weight management services.
Enter "Zero" if the intervention is not provided to members in the weight management program. Check all that apply. Note that selection of the following four (4) response options require documentation as Healthy 3:

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

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

	Availability of intervention	Cost of intervention	Number of participants in 2013-regional preferred - refer to question above	Is Number of participants provided regional or national?	Percent receiving intervention (denominator is from 3.8.1 second to last row)
Printed (not online) self-management support tools such as BMI wheels, pedometer, or daily food and activity logs	*Single, Pull-down list.* 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in weight management program	*Multi, Checkboxes.* 1: Included as part of weight management program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No weight management program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No weight management program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee), 6: No weight management program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No weight management program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	*Decimal.* From 0 to 10000000000000.	*Single, Radio group.* 1: Regional, 2: National	Unknown
Web and printed educational materials about BMI and importance of maintaining a healthy weight	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online interactive support that might include tools and/or chat sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Telephonic coaching that is obesity-centric. (Obesity is key driver of contact as opposed to discussion in context of some other condition)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In-person group sessions or classes that are obesity centric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Obesity-centric Telephonic or in-person family counseling to support behavior modification	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pedometer and/or biometric scale or other device for home monitoring and that electronically feeds a PHR or EMR	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pharmacological Therapies					

Benefit coverage of FDA approved weight loss drugs	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other					
Affinity programs (e.g. - discounts for Weight Watchers, fitness center discounts)	AS ABOVE	AS ABOVE	*Decimal.* From 0 to 10000000000000.	*Single, Radio group.* 1: Regional, 2: National, 3: Offered but not tracked	Unknown

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

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

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

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

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

HMO Response	Coverage options	Copay, deductible, or incentive plan options
Over-the-counter aids (e.g. Alli) discounted, free, or available at copay	*Multi, Checkboxes.* 1: Included as part of weight management program with no additional fee, 2: Available in weight management program with an additional fee, 3: Available in weight management program, but may require an additional fee, depending on contract, 4: No weight management program, but weight management pharmaceuticals covered under pharmacy benefit for fully insured lives, 5: No weight management program, but weight management pharmaceuticals covered under pharmacy benefit for self-insured lives, 6: Not Covered	*Multi, Checkboxes.* 1: Standard copay/discount only, 2: Copay/discount or deductible incentive is variable based on program participation, 3: Medication is available on lowest cost (or no cost) tier, 4: Limitation on number of fills per year, 5: Prior authorization or step therapy required, 6: Available as rider only
Xenical (Orlistat)	AS ABOVE	AS ABOVE
Phentermine or branded equivalents	AS ABOVE	AS ABOVE
Lorcaserin	AS ABOVE	AS ABOVE

8.3.8.6 PPO version of above.

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

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

8.3.8.8 PPO version of above.

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

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

8.3.8.10 Review the 2013 and 2012 QC HEDIS uploaded results for the HMO Plan. The HEDIS measures eligible for rotation for QC 2013 are Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents and Adult BMI Assessment.

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

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

Please refer to the attached document for an explanation of terms

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

	2013 HMO QC results	2012 HMO QC results or Prior Year results for Rotated measure
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total) (Eligible for rotation in QC 2013)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total) (Eligible for rotation in QC 2013)	AS ABOVE	AS ABOVE.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total) (Eligible for rotation in QC 2013)	AS ABOVE	AS ABOVE.
Adult BMI assessment (Total) (Eligible for rotation in QC 2013)	AS ABOVE	AS ABOVE.

8.3.8.11 PPO version of above.

8.3.9 CAHPS Performance

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

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

Please refer to the attached document for an explanation of terms

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

Provide percentage of members who responded “Always” or “Usually”	HMO QC 2013	HMO QC 2012
Survey Item: How often did the written materials or the Internet provide the information you	*Percent.*	*Percent.*

needed about how your health plan works?	From -10 to 100.	From -10 to 100.

8.3.9.2 PPO version of above.

8.3.10 Other Information

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

Is Healthy 4 provided?

Single, Pull-down list.
1: Yes with a 4 page limit,
2: Healthy 4 is not provided

8.4 HELPING MEMBERS BECOME GOOD CONSUMERS

8.4.1 Instructions and Definitions

8.4.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

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

8.4.1.3 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5.

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

8.4.2 Addressing language and health literacy needs

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

Please describe below plan activities to address health literacy.

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

8.4.2.2 Indicate how racial, ethnic, and/or language data is used? Check all that apply.

Multi, Checkboxes.
1: Assess adequacy of language assistance to meet members' needs,
2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language,
3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
4: Identify areas for quality improvement/disease management/ health education/promotion,
5: Share with enrollees to enable them to select concordant clinicians,
6: Share with provider network to assist them in providing language assistance and culturally competent care,
7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),
8: Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),
9: Analyze disenrollment patterns,
10: Develop disease management or other outreach programs that are culturally sensitive (provide details on program in detail box below),
11: Other (describe in detail box below),
12: Racial, ethnic, language data is not used

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

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

8.4.2.4 Indicate which of the following activities the Plan undertook in 2013 to assure that culturally competent health care is delivered. This shall be evaluated with regard to language, culture or ethnicity, and other factors. Check all that apply.

Multi, Checkboxes.
1: Assess cultural competency needs of members,
2: Conduct an organizational cultural competence assessment of the Plan,
3: Conduct a cultural competence assessment of physician offices,
4: Employ a cultural and linguistic services coordinator or specialists,
5: Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,
6: Collaborate with statewide or regional medical association groups focused on cultural competency issues,
7: Tailor health promotion/prevention messaging to particular cultural groups (summarize groups targeted and activity in detail box),
8: Tailor disease management activities to particular cultural groups (summarize activity and groups targeted in detail box),
9: Public reporting of cultural competence programs, staffing and resources,
10: Sponsor cultural competence training for Plan staff,
11: Sponsor cultural competence training for physician offices,
12: Other (describe in detail box below):,
13: No activities in year of this response

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

Yes/No.

8.4.3 Alignment of Benefit Design and Incentives

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

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

member can see claims, cost and quality on physicians, etc.		

8.4.3.2 PPO version of above.

8.4.4 Electronic Personal Health Record (PHR)

8.4.4.1 Describe the Plans electronic personal health record.

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

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

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

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

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

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

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

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

	8: Any reminder, order, and prescription, etc. recommended by the care management and disease management program for the patient., 9: Lab tests completed with push notification to member, 10: Lab values with push notification to member, 11: X-ray interpretations with push notification to member, 12: None of the above

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

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

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

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

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

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

8.4.5 Help Finding the Right Doctor

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

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

	Response
Physician office hours	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician years in practice	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician facility privileges	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician languages spoken	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
NCQA Diabetes Recognition Program [attach documentation] CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify.	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available

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

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

Multi, Checkboxes.
1: Consumer 2a on NCQA recognition programs is provided,
2: Consumer 2b on use of web visits is provided,
3: Consumer 2c on use of email is provided,
4: Consumer 2d on use of e-prescribing is provided,
5: Consumer 2e on use of EMR is provided,
6: Not provided

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

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

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

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

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in network – please insert this number in appropriate column - newly created last column

Only one of the last two columns needs a %response – system will not allow plan to save responses if both of the last 2 columns have responses

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf and "Advancing Physician Performance Measurement: Using Administrative Data to Assess Physician Quality and Efficiency" available at http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

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

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

Category of PQRS Measure & Other Measures	Level of detail for comparative public reporting of physicians who meet the threshold of reliability for reporting. (HMO)	Indicate if reporting covers primary care and/or specialty physicians (HMO)	Description of Other (if plan selected response option 6)	(preferred) Physicians (PCP and SCP) in the relevant specialties being reported on as % of total contracted physicians (Denominator = all PCPs and relevant specialists) (HMO)	(alternate) Physicians being reported on as % total contracted physicians in market (Denominator = all PCPs and all specialists in network) (HMO)
Diabetes Mellitus (A)	*Multi, Checkboxes.* 1: Individual Physician, 2: Practice Site, 3: Medical Group/IPA/Staff model Group, 4: PCMH, 5: ACO, 6: Other (describe), 7: None of the above	*Multi, Checkboxes.* 1: Primary care, 2: Specialty	*50 words.*	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK. From 0 to 100.
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention) (B)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Coronary Artery Bypass Graft (C)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Perioperative Care (C)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Back pain (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Coronary Artery Disease (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.
Heart Failure (A)	AS ABOVE	AS ABOVE.	AS ABOVE	AS ABOVE	AS ABOVE.

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

8.4.5.4 PPO version of above.

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

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

Single, Pull-down list.
1: Consumer 3 is provided,
2: Not provided

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

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

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

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

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

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

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

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

	Answer
Distinction of higher performing individual physicians	*Single, Radio group.* 1: No distinction, 2: Distinction is made
General education about individual physician performance standards	*Single, Radio group.* 1: Yes, 2: No
Education and information about which individual physicians meet target practice standards	AS ABOVE
Messaging included in EOB if member uses provider not designated as high performing relative to peers	AS ABOVE
Member steerage at the time of nurseline interaction or telephonic treatment option support	AS ABOVE
Members are not actively encouraged at this time to utilize individual physicians that meet targeted practice standards	AS ABOVE

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

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

HMO Response	Answer	Technology	Geography of response

Plan ability to support web/telehealth consultations	*Multi, Checkboxes.* 1: Plan does not offer/allow web or telehealth consultations, 2: Web visit with structured data input of history and symptom, 3: Telehealth with interactive face to face dialogue over the Web		*Single, Radio group.* 1: Regional, 2: National
Plan uses a vendor for web/telehealth consultations (indicate vendor)	*50 words.*	*Single, Radio group.* 1: Web, 2: Telehealth, 3: Combination of Web and Telehealth	AS ABOVE
If physicians are designated in provider directory as having Web/Telehealth consultation services available, provide number of physicians in the region	*Decimal with 100 words.* N/A OK.	AS ABOVE	AS ABOVE
Member reach of physicians providing web/telehealth consultations (i.e., (what % of members are attributed to those physicians offering web/telehealth consultations) (use as denominator total commercial membership in market from 1.3.2 or if national response from 1.3.3)	*Percent.* N/A OK.	AS ABOVE	AS ABOVE
If members are able to schedule web/telehealth consultations with some physicians, provide percent of members using those physicians (use as denominator total commercial membership in market from 1.3.2 or if national response from 1.3.3)	*Percent with 100 words.* N/A OK. From 0 to 100.	AS ABOVE	AS ABOVE
Number of web/telehealth consultations performed in 2013 per thousand commercial members (based on total commercial membership in 1.3.2 or if national response from 1.3.3)	*Decimal.* N/A OK. From 0 to 100000000000.	AS ABOVE	AS ABOVE
Number of web/telehealth consultations performed in 2012 per thousand members	*Decimal.* N/A OK.	AS ABOVE	AS ABOVE
Plan provides a structured template for web/telehealth consultations (versus free flow email)	*Single, Radio group.* 1: Yes, 2: No	AS ABOVE	AS ABOVE
Plan reimburses for web/telehealth consultations	*Single, Radio group.* 1: Yes, 2: No	AS ABOVE	AS ABOVE
Plan's web/telehealth consultation services are available to all of members/employers	*Single, Radio group.* 1: Yes - with no additional fee, 2: Yes - additional fee may be assessed, depending on contract, 3: Yes - always for an additional fee, 4: No	AS ABOVE	AS ABOVE

8.4.5.10 PPO version of above.

8.4.6 Hospital Choice Support

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

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

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

The AHRQ Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time. The current AHRQ QI modules represent various aspects of quality:

- Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care. http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx
- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx
- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. http://www.qualityindicators.ahrq.gov/Modules/psi_overview.aspx

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

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

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

Denominator: all hospitals in network

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

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

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

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

Single, Pull-down list.
1: Consumer 5 is provided,
2: Not provided

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

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

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

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

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

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

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

8.4.7 Shared Decision-Making and Treatment Option Support

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

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

8.4.7.2 Indicate which of the following functions are available with the interactive treatment option decision support tool. Check all that apply. If any of the following six (6) features are selected, documentation for the procedure KNEE REPLACEMENT must be provided in following question as Consumer 7:

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

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

	Answer
Content	*Multi, Checkboxes.* 1: Describes treatment/condition, i.e. symptoms, stages of disease, and expectations/trade offs from treatment, 2: Includes information about what the decision factors are with this condition, 3: Treatment options include benefits and risks, 4: Tool includes likely condition/quality of life if no treatment, 5: Includes information about patients' or caregivers' role or responsibilities, 6: Discloses reference documentation of evidence base for treatment option, 7: Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision, 8: Provides member with questions or discussion points to address with provider or enables other follow up option, e.g. health coach option, 9: None of the above
Functionality	*Multi, Checkboxes.* 1: Allows user to organize/rank preferences, 2: User can compare treatment options side-by-side if reasonable options exist, 3: None of the above
Telephonic Support	*Multi, Checkboxes.* 1: Member can initiate call to discuss treatment options with clinician, 2: Plan or vendor may make outbound call to targeted member based on identified triggers (e.g., course of treatment, authorization request, etc.), 3: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Tailored to member's demographic attributes (e.g., age, gender, etc.), 2: Tailored to the progression of the member's condition, 3: Elicits member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.), 4: Tailored to member's specific benefits design, such that co-pays, OOP max, deductible, FSA and HSA available funds, and relevant tiered networks or reference pricing are all present in cost information, 5: None of the above
Cost Information/functionality	*Multi, Checkboxes.* 1: Treatment cost calculator based on the Plan's fee schedule but not tied to selection of specific providers, 2: Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, 3: Treatment cost calculator based on billed charges in the local market, 4: Treatment cost calculator based on paid charges in the local market, 5: Specific to the member's benefit coverage (co-pays, OOP max, deductible, FSA and HSA available funds) to reflect potential out-of-pocket costs, 6: Treatment cost calculator includes medication costs, 7: Treatment cost calculator does not include medication costs – information is not integrated, 8: Treatment cost per an alternative method not listed above (describe in detail box below):, 9: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool to cost calculator and user populates relevant information,, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe in detail box below), 4: There is no integration of cost calculator with this tool
Description of "Other"	*200 words.*

8.4.7.3 If any of the following six (6) features are selected in question 4.7.2 above, actual report(s) or screen prints illustrating each interactive feature selected **for the procedure KNEE REPLACEMENT** as Consumer 7: 1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure), 2) Treatment options include benefits and risks, 3) Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision , 4) Information tailored to the progression of the member's condition, 5) Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, and 6) Linked to the member's benefit coverage to reflect potential out-of-pocket costs.

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

Multi, Checkboxes.
1: Consumer 7a (Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)) is provided,
2: Consumer 7b (Treatment options include benefits and risks) is provided,
3: Consumer 7c (Provides patient narratives/testimonials) is provided,
4: Consumer 7d (Information tailored to the progression of the member's condition) is provided,
5: Consumer 7e (based on the Plan's fee schedule and selection of specific providers) is provided,
6: Consumer 7f (Linked to the member's benefit coverage to reflect potential out-of-pocket costs) is provided,
7: Not provided

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

Multi, Checkboxes.
1: Claims or clinical record profiling,
2: Specialty care referral process,
3: Personal Health Assessment,
4: Nurse advice line referral,
5: Care/case management support,
6: None of the above activities are used to identify specific treatment option decision support outreach

8.4.7.5 How does the Plan evaluate the use and impact of its treatment option support? The commercial enrollment reported below should match the statewide number reported in Profile 1.3.3.

	2013	2012
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: Not available	*Multi, Checkboxes - optional.* 1: Not available
Total commercial enrollment from plan's response in profile 1.3.3 (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison.* 0	
Enrollment (list Total commercial number reported in Profile 1.3.3)	*Decimal.*	*Decimal.*
Number of completed interactive sessions with treatment option support tool	*Decimal.* N/A OK. From 0 to 10000000000000.	*Decimal.* N/A OK. From 0 to 10000000000000.
Number of unique users to site	*Decimal.* N/A OK. From 0 to 1000000000.	*Decimal.* N/A OK. From 0 to 1000000000.
Number of unique users making inbound telephone calls	*Decimal.* N/A OK.	*Decimal.* N/A OK.
Number of unique users receiving outbound telephone calls	*Decimal.* N/A OK.	*Decimal.* N/A OK.
Percentage of unique Website users to total enrollment [autocalc]	*For comparison.* 0.00%	*For comparison.* 0.00%
Percentage of unique users for telephonic treatment option decision support (inbound and outbound) [autocalc]	*For comparison.* 0.00%	*For comparison.* 0.00%
Targeted follow-up via email or phone call to assess user satisfaction	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Yes, 2: No
Measuring change in utilization patterns for preference-sensitive services (e.g., back surgery, prostate surgery, etc.)	*Multi, Checkboxes.* 1: Volume of procedures, 2: Paid claims, 3: None of the above	*Multi, Checkboxes.* 1: Volume of procedures, 2: Paid claims, 3: None of the above
Plan can report utilization aggregated at the purchaser level	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Yes, 2: No

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

8.4.8.1 Describe activities to identify for members/consumers those providers (hospitals and/or physicians) that are more efficient and/or lower cost.

Single, Radio group.
1: Description,
2: Plan does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

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

	Physicians	Hospitals	Ambulatory surgery or diagnostic centers
Procedure-based cost	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Regional or provider average billed charges, 4: Regional or provider average paid charges, 5: Provider specific contracted rates,

	charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members, 8: Information available to public	charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members, 8: Information available to public	6: Cost information not available, 7: Information available only to members, 8: Information available to public
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	AS ABOVE	AS ABOVE	AS ABOVE

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

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

	Answer
	Multi, Checkboxes - optional. 1: The Plan does not support a cost calculator.
Content	*Multi, Checkboxes.* 1: Medical cost searchable by procedure (indicate number of procedures in detail box below), 2: Medical cost searchable by episode of care (indicate number of care episodes in detail box below), 3: Medication costs searchable by drug, 4: Medication costs searchable by episode of care, 5: None of the above
Functionality	*Multi, Checkboxes.* 1: Compare costs of alternative treatments, 2: Compare costs of physicians, 3: Compare costs of hospitals, 4: Compare costs of ambulatory surgical or diagnostic centers, 5: Compare drugs, e.g. therapeutic alternatives, 6: Compare costs based on entire bundle of care, allowing user to substitute lower cost or higher quality equivalent elements of bundle, 7: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions, 2: Cost information considers members benefit design relative to accumulated deductibles, Out of Pocket max, lifetime, services limits (e.g. number of physical therapy visits covered), 3: Cost information considers members benefit design relative to pharmacy benefit, e.g. brand/generic and retail/mail, 4: Separate service category sets result for user, other adult household members and for children, 5: Explains key coverage rules such as family-level versus individual-level annual accumulation and general rules about portability, accrual, tax allowances, etc, 6: Provides summary plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above
Account management / functionality	*Multi, Checkboxes.* 1: Supports member entry of tax status/rate to calculate federal/state tax ramifications, 2: Member can view multi-year HSA balances, 3: Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses, 4: None of the above

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

1) Demonstrate the search options available for this procedure (e.g., name, condition, symptom and/or procedure)
2) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,
3) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,
4) Supports member customization of expected ***professional*** services utilization or medication utilization,
5) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses

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

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

8.4.9 HEDIS and CAHPS Performance

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

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

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

Please refer to the attached document for an explanation of terms

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

	HMO QC 2013	HMO QC 2012
Getting needed care composite Provide percentage of members who responded “Always” or “Usually”	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Getting care quickly composite Provide percentage of members who responded “Always” or “Usually”	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Customer service composite Provide percentage of members who responded “Always” or “Usually”	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

8.4.9.2 PPO version of above.

8.4.10 Other Information

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

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

8.5 Helping Members Manage Acute/ Episodic Conditions and Advanced Care

8.5.1 Alignment of Plan Design

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

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

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

Please respond accordingly in the last column.

HMO Response- Acute Care Services	Financial Incentives	Product availability	Uptake as % of total commercial statewide	Percentage is based on plan's entire commercial membership in all markets

			membership as noted in 1.3.3	of plan operation
A: Incentives contingent upon member behavior				
Participation in shared decision program prior to proceeding with treatment	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*
B: Incentives not contingent on participation or completion				
Use of more cost-effective treatment alternatives	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx, 2: Part of program with reduced Premium Share, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services, 4: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*

8.5.1.2 PPO version of above

8.5.2 Obstetrics and Maternity and Child

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

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

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

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

8.5.2.3 Indicate all of the following that describe the Plan's policies regarding normal (not high risk) labor and delivery. Check all that apply.

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

8.5.2.4 Please report the 2013 and 2012 Cesarean delivery rates and VBAC rates using the AHRQ, NQF and Joint Commission specifications. Please see the attachment for the Admission to NICU (Neonatal Intensive Care) worksheet to respond to question on NICU admissions. The document can also be found in "Manage Documents".

Regional/Statewide responses are preferred.

Detailed specifications can be accessed here:

AHRQ: Cesarean Delivery Rate: http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V41/TechSpecs/IQI 33 Primary Cesarean Delivery Rate.pdf

NQF: NTSV Cesarean Rate: http://manual.jointcommission.org/releases/TJC2013A/MIF0167.html

Joint Commission: Rate of Elective Deliveries: http://manual.jointcommission.org/releases/TJC2013A/MIF0166.html

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

NQF: NICU Admission Rates: See attached PDF

	Calculated	2013 Statewide Rate	2012 Statewide Rate	2013 Rate in market	2012 Rate in market
AHRQ Cesarean Delivery Rate	*Single, Radio group.* 1: Calculated, 2: Not calculated	*Percent.* N/A OK. From -10 to 100.	*Percent.* N/A OK. From -10 to 100.	*Percent.* N/A OK. From -10 to 100.	*Percent.* N/A OK. From -10 to 100.
NQF NTSV Cesarean Delivery Rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Joint Commission Rate of Elective Deliveries	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
AHRQ VBAC Rate Uncomplicated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
NQF NICU Admission Rates	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.5.2.5 Review the two most recently uploaded QC 2013 and QC 2012 HMO results for the Plan for each measure listed.

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

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

Please refer to the attached document for an explanation of terms

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

	HMO QC 2013, or Most Current Year HMO QC Results	2012 HMO QC results or Prior Year QC Results
Chlamydia Screening in Women - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	AS ABOVE	AS ABOVE
Prenatal and Postpartum Care - Postpartum Care	AS ABOVE	AS ABOVE
Well-Child Visits in the first 15 months of life (6 or more visits)	AS ABOVE	AS ABOVE
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	AS ABOVE	AS ABOVE
Adolescent Well-Care Visits	AS ABOVE	AS ABOVE

8.5.2.6 PPO version of above.

8.5.2.7 Identify Plan strategies in calendar year 2013 for payment, education and policy initiatives designed to address the rising rates of cesarean deliveries and elective inductions. Check all that apply. **Indicate whether related to cesarean delivery and/or inductions, and *include relevant results of efforts*.**

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

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

8.6 HELPING MEMBERS MANAGE CHRONIC CONDITIONS

8.6.1 Instructions and Definitions

8.6.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. **The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.**

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

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

8.6.1.4 This module focuses on Coronary Artery Disease, Diabetes and Behavioral Health. Asthma was eliminated as an area of focus for 2010 due to the limited value of the HEDIS indicator and relatively high process scores. Back pain was eliminated in 2011 because the condition did not coordinate well with diabetes and CAD. Questions are asked in "Program Scope" about other clinical programs to understand breadth of the Plan's disease management efforts. Employers may request information on these programs outside of the eValue8 initiative.

8.6.1.5 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

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

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

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

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

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

	Reach of condition management programs offered	Cost of Program Availability	Vendor Name if plan outsources or jointly administers	*Specify primary condition(s) (If applicable)
Alzheimer's disease	*Multi, Checkboxes.* 1: Plan-wide and available to all commercial members identified with condition,, 2: Managed only as a comorbidity (*specify primary condition(s) 3: Available in all markets including this one, 4: Available only in specific markets including this one,	*Multi, Checkboxes.* 1: Available to fully insured members as part of standard premium, 2: Available as part of standard ASO fee for self-insured members (no additional fee assessed), 3: Employer option to purchase for additional fee for fully insured	*50 words.* Nothing required	*65 words.*

	5: Available only in specific markets BUT NOT this one, 6: No disease management program	members, 4: Employer option to purchase for additional fee for self-insured members		
Arthritis (osteo and/or rheumatoid)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma - Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Back pain	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
CAD (CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Cancer	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Chronic obstructive pulmonary disease (COPD)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Congestive heart failure (CHF)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
High risk pregnancy	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Migraine management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pain management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Stroke	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Risk factor based total population management (Not disease specific)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

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

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

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

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

1) the information is electronically entered into the record from another electronic source like claims or a web-based electronic personal health assessment tool without manual re-entry or entry resulting from contact with the plan member, AND

2) there is a single case record per member that unifies all care management functions conducted by the plan, including large case management, disease management, health and wellness coaching, etc.

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

	System administration arrangement for disease management
Inpatient medical claims/encounter data	*Single, Radio group.* 1: Data is electronically populated in a unified record for DM care management for all members, 2: Data is manually entered into a unified record for all members, 3: Data is electronically populated in a unified record for DM care management for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH),, 4: Data is manually entered into a unified record for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH),, 5: This functionality / element is not available or is manually entered by care management staff
Medical claims/encounter data	AS ABOVE
Pharmacy claims data	AS ABOVE
Lab test claims data	AS ABOVE
Lab values	AS ABOVE
Behavioral health claims/encounter data	AS ABOVE
Member response to a Health Assessment (HA), formerly known as PHA or HRA) if available	AS ABOVE
Results from home monitoring devices (electronic scales, Health Buddy, heart failure monitoring devices, etc)	AS ABOVE
Results from worksite biometric or worksite clinic sources	AS ABOVE
Information from case manager or nurses notes	AS ABOVE

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

	Medical Management Services	Describe
When do you initiate outreach for case management referrals?	*Single, Radio group.* 1: Within 24-48 hours, 2: Within 3-5 business days, 3: Within 6-10 business days, 4: Other (describe)	*50 words.*
Do you have a program that provides help to an individual transitioning between care settings?	*Multi, Checkboxes.* 1: Home to and from Hospital, 2: Skilled Nursing Care to and from Hospital, 3: Rehabilitation Care to and from Hospital, 4: Other (describe)	*500 words.*
Describe how you identify and engage high-risk, medically complex patients for a high-intensity	*Single, Radio group.* 1: Provider referral, 2: Prospective risk score (include threshold and methodology description, 3: Frequency of admission or emergency department use, 4: Outbound call to patient,	*500 words.*

case management program.	5: Face-to-face patient visit, 6: Other (describe)	
Describe the measurement strategy in your high-intensity case management programs.	*Multi, Checkboxes.* 1: Member Satisfaction, 2: Inpatient Admission Rates, 3: Emergency Department Use Rates, 4: Complication Rates, 5: Readmission Rates, 6: Clinical Outcome Quality, 7: Other (describe), 8: No Measurement Strategy in Place	*500 words.*

8.6.2.5 How does the Plan determine and ensure that members with chronic conditions are screened for depression based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event**. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis.** Availability of the general Plan HA (Health Assessment) does NOT qualify unless it is specifically promoted to members in the Chronic Condition Management (CCM) program (not just through general messages to all health plan members) and used by the CCM program staff.

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

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

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

8.6.3 Member Identification and Support for CAD and Diabetes

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

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

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

Please respond accordingly in the last column.

HMO Response - services related to chronic conditions	Financial Incentives	Product availability	Uptake as % of total commercial statewide membership noted in 1.3.3	Percentage is based on plan's entire commercial membership in all markets of plan operation
A: Incentives contingent upon member behavior				
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching biometric goals (e.g., BMI level or change, HbA1c improvement or levels, etc.), 5: Waived or decreased co-payments/deductibles for use of selected chronic care medications, 6: Incentives to adhere to evidence-based self-management guidelines, 7: Incentives to adhere to recommended care coordination encounters, 8: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* N/A OK. From 0 to 100.	*Yes/No.*
Participation in other Plan-designated high performance practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Participation in chronic condition management coaching	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Not supported	AS ABOVE	AS ABOVE	AS ABOVE
Adherence to chronic condition management guidelines (taking tests, drugs, etc. as recommended)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success with specific target goals for chronic condition management (HbA1c levels, LDL levels, BP levels, etc.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
B: Incentives not contingent on participation or completion				
Asthma	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx, 2: Part of program with reduced Premium Share, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services, 4: Not supported	AS ABOVE	AS ABOVE	*Yes/No.*
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Depression	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

8.6.3.2 PPO version of above.

8.6.3.3 For the total commercial book of business in this market, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above with CAD using the NCQA "Eligible Population" definition for Cardiovascular Disease in the second row, and (3) the number of members eligible for participation in the DM program based on Plan's criteria (NOT Prevalence). **Refer back to Plan response in 6.2.1.**

Starting at row 4, based on the Plan's stratification of members with CAD, indicate the types of interventions that are received by the population based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. **Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis**. Enter "Zero" if the intervention is not provided to members with CAD. Select "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention. Select "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program. Select online interactive self-management only if the application involves customized information based on branch logic. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include static web information. A member is "actively engaged" in the outbound telephonic program if they participate beyond the initial coaching call.

For member counts use the number of members as of December 31st, 2013 who participated in the activity at any time during 2013.**If participation rates provided are not market –specific – please note in detail box**

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to CAD Patients in this state/market	Number of members in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)	Is Intervention standard or buy-up option (Cost of Intervention)	Risk strata that receives this intervention	Autocalculated % of HEDIS CAD eligible who received intervention	Autocalculated % of Plan CAD eligible who received intervention
Number of members aged 18 and above in this market	*Decimal.*						
Using the NCQA "Eligible Population" definition for Cardiovascular disease on pages 138-139 of the 2013 HEDIS Technical Specifications Vol 2., provide number of members 18 and above with CAD	*Decimal.*						
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in CAD DM program	*Decimal.*						
General member education (e.g., newsletters)		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal.* From 0 to 100000000000000.	*Multi, Checkboxes.* 1: Included as part of CAD program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No CAD program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No CAD program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee),	*Multi, Check boxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown

				6: No CAD program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No CAD program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available			
General care education/reminders based on condition alone (e.g., personalized letter)		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Member-specific reminders for a known gap in clinical/diagnostic maintenance services Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Member-specific reminders for medication events (e.g., level of use, failure to refill) Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number provided, 6: Offered but not tracked regionally or nationally	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Self-initiated text/email messaging		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

		provided, 6: Offered but not tracked regionally or nationally					
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention.		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
IVR with outbound messaging only		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

8.6.3.4 For the total commercial book of business in this market, please provide (1) the number of members aged 18 and above in the first row, (2) the number of members aged 18 and above with Diabetes using the NCQA "Eligible Population" definition for Diabetes in the second row, and (3) the Members eligible for participation in the DM program based on Plan's criteria (NOT Prevalence). **Refer back to Plan response in 6.2.1.**

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

For member counts use the number of members as of December 31st, 2013 who participated in the activity at any time during 2013.**If participation rates provided are not market –specific – please note in detail box.**

	Number of members as specified in rows 1, 2 and 3	Indicate if intervention Offered to Diabetes Patients in this state/market	Number of members 18 years and above in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)	Is intervention a standard or buy-up option (Cost of Intervention)	Risk strata that receives this intervention	Autocalculated % of HEDIS Diabetes eligible who received intervention	Autocalculated % of Plan Diabetes eligible who received intervention
Number of members aged 18 and above in this market	*Decimal.*						
Using the NCQA "Eligible Population" definition for Diabetes on pages 153-155 of the 2013 HEDIS Technical Specifications Vol 2., provide number of members 18 and above	*Decimal.*						

with Diabetes							
Using the plan's own criteria, provide number of members identified with condition and eligible to participate in diabetes DM program	*Decimal.*						
General member education (e.g., newsletters)		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal.* From 0 to 100000000000.	*Multi, Checkboxes.* 1: Included as part of Diabetes program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No Diabetes program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No Diabetes program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No Diabetes program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No Diabetes program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	*Multi, Check boxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown
General care education/reminders based on condition alone (e.g., personalized letter)		AS ABOVE	*Decimal.* From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Member-specific reminders for due or overdue clinical/diagnostic maintenance services Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program (Documentation needed)		AS ABOVE	*Decimal.* From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Member-specific reminders for medication events (e.g., level of use, failure to refill) Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program (Documentation needed)		AS ABOVE	*Decimal.* From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered, 4: Regional Number provided, 5: National Number provided,	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)		6: Offered but not tracked regionally or nationally					
Self-initiated text/email messaging		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves information capture of member response information for record updates and/or triggering additional intervention.		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
IVR with outbound messaging only		AS ABOVE	*Decimal.* From 0 to 100000000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown
Live outbound telephonic coaching program (count only members that are successfully engaged)		*Multi, Check boxes.* 1: HMO, 2: PPO, 3: Intervention not offered	*Decimal.* From 0 to 100000000000.	AS ABOVE	AS ABOVE	Unknown	Unknown

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

	Services Monitored	Data Source in general, not per service
CAD	*Multi, Checkboxes.* 1: Blood pressure levels, 2: Beta Blocker Use, 3: LDL testing, 4: LDL control, 5: Aspirin therapy, 6: Gaps in Rx fills, 7: Other, 8: Not monitored	*Multi, Checkboxes.* 1: Medical records, 2: Claim feed, 3: RX Data Feed, 4: Vendor feed (lab, x-ray), 5: Patient Self-Report, 6: Patient home monitoring
Diabetes	*Multi, Checkboxes.* 1: Retinal Exam, 2: LDL Testing, 3: LDL Control, 4: Foot exams, 5: Nephropathy testing, 6: HbA1c Control, 7: Blood pressure (130/80), 8: Blood pressure (140/90), 9: Gaps in Rx fills, 10: Other, 11: Not monitored	*Multi, Checkboxes.* 1: Medical records, 2: Claim feed, 3: RX Data Feed, 4: Vendor feed (lab, x-ray), 5: Patient Self-Report, 6: Patient home monitoring

8.6.3.6 If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in the questions above (Q 6.3.3 and/or 6.3.4), provide an actual, blinded copy of the reminders or telephone scripts as CC 1a, 1b, 1c (if applicable). If the mailing/telephone script(s) does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service or Rx refill, please provide further evidence that the reminder targeted members who were due or overdue for the service. Check the boxes below to indicate the disease states illustrated in the reports and whether the reminders addressed more than one service element (e.g., LDL and HbA1c tests for diabetics).

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

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

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

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

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

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

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

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

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

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

8.6.4 Performance Measurement: CAD and Diabetes

8.6.4.1 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2013 and QC 2012. The HEDIS measure eligible for rotation for QC 2013 is Cholesterol Management for Patients with Cardiovascular Conditions. Screening and Control rates for these measures must be rotated together.

If plan rotated Cholesterol Management for Patients with Cardiovascular Conditions for QC 2013, QC 2013 would be based on QC 2012, so the prior year data that would be uploaded would be QC 2011.

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

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

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

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

	HMO QC 2013	HMO QC 2012, or Prior Year Results for rotated measure
Controlling High Blood Pressure - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Persistence of Beta-Blocker treatment after a heart attack	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL) (Eligible for rotation in QC 2013)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening (Eligible for rotation in QC 2013)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

8.6.4.2 PPO version of above.

8.6.4.3 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2013 and QC 2012. The HEDIS measures eligible for rotation for QC 2013 are any Comprehensive Diabetes Care measure. Note that the screening and control rates for these measures must be rotated together. The HbA1c Control <7% for a Selected Population indicator must be rotated with all the other HbA1c indicators in the CDC measure.

If plan rotated any of the Comprehensive Diabetes Care Measures for QC 2013, QC 2013 would be based on QC 2012, so the prior year data that would be uploaded would be QC 2011.

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

-1 means 'NR'

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

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

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

	HMO QC 2013 results	HMO QC 2012 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Comprehensive Diabetes Care - HbA1c Testing	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - LDL-C Screening	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Medical Attention for Nephropathy	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 8%	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 7% for a Selected Population	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - LDL-C Controlled (LDL-C<100 mg/dL)	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	AS ABOVE.	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	AS ABOVE.	AS ABOVE

8.6.4.4 PPO version of above.

8.6.5 Plan Organization for Behavioral Health Management

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

Multi, Checkboxes.
1: BH practitioners are listed in the Plan's print/online directory,
2: Members call the Plan to identify an appropriate practitioner,
3: Members call the MBHO to identify an appropriate practitioner,
4: Members call the BH practitioner office directly,
5: Other (describe in detail box below),
6: Not applicable/all BH services are carved out by the employers

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

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

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

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

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

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

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

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

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

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

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

Screening			
Depression Management	AS ABOVE	AS ABOVE	*50 words.*

8.6.6 Member Screening & Support in Behavioral Health

8.6.6.1 If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in question 6.6.2 above, provide an actual, blinded copy of the reminder as CC 4. If the reminder does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service, please provide further evidence that the reminder targeted members who were due or overdue for the service. Check the boxes below to indicate the disease states illustrated in the reports and whether the reminders addressed more than one service element. If the plan indicates that it monitors services for gaps, indicate which services are monitored. If the "other" choice is selected, describe the service that is monitored in the text box. The Plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

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

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

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

	Drugs that are monitored for adherence	Entity responsible for monitoring and acting on adherence	Members monitored	Actions taken	Briefly describe role of Plan in Reminder/ Alert Program	Other (describe) Action Taken and/or Responsible Party
Behavioral Health	*Multi, Checkboxes.* 1: Antidepressants, 2: Atypical antipsychotics, 3: Other (describe), 4: Compliance (medication refills) is not systematically assessed	*Multi, Checkboxes.* 1: Plan personnel, 2: PBM, 3: Retail or mail pharmacy, 4: Other (describe)	*Single, Radio group.* 1: All members taking the checked drugs are monitored, 2: Only DM participants are monitored	*Multi, Checkboxes.* 1: Member must activate reminders, 2: Member receives mailed reminders, 3: Member receives electronic reminder (e.g. email), 4: Member receives telephone contact, 5: Practitioner is mailed an alert, 6: Practitioner is contacted electronically, 7: Practitioner is contacted by telephone, 8: Telephonic coach is notified, 9: Gap in fills are communicated electronically to personal health record which will trigger a member alert, 10: Other (describe)	*100 words.*	*100 words.*
Substance Use Disorders	AS ABOVE	AS ABOVE	AS ABOVE monitored	AS ABOVE	*100 words.*	*100 words.*

8.6.7 Performance Measurement: Behavioral Health

8.6.7.1 Review the two most recently calculated years of HEDIS results for the Plan's HMO Product. Measures not eligible for rotation in QC 2013. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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

-5 means 'NB'

Please refer to the attached document for an explanation of terms

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

	QC 2013 result	QC 2012 result
Identification of Alcohol & Other Drug Dependence Services - % Members Receiving Any Services	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

8.6.7.2 PPO version of above.

8.6.7.3 Review the two most recently calculated years of HEDIS results for the Plan's HMO product. Measures not eligible for rotation in QC 2013. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

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

Please refer to the attached document for an explanation of terms

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

	QC 2013 result	QC 2012 result
Mental Health Utilization - % Members Receiving Services - Any	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
FU After Hospitalization For Mental Illness - 7 days	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
FU After Hospitalization For Mental Illness - 30 days	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Antidepressant Medication Management - Effective Acute Phase Treatment	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Antidepressant Medication Management - Effective Continuation Phase Treatment	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
FU Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	*Decimal.* From -10 to 100.	*Decimal.* From -10 to 100.
FU Care for Children Prescribed ADHD Medication - Initiation	*Decimal.* From -10 to 100.	*Decimal.* From -10 to 100.

8.6.7.4 PPO version of above.

8.6.8 Performance Measurement: Other Conditions

8.6.8.1 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2013 and QC 2012. This was not a rotated measure.

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

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

Please refer to the attached document for an explanation of terms

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

	HMO QC 2013	HMO QC 2012
COPD: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

8.6.8.2 PPO version of above.

8.6.8.3 Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2013 and QC 2012. This was not a rotated measure.

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

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

Please refer to the attached document for an explanation of terms

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

	HMO QC 2013	HMO QC 2012
Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

8.6.8.4 PPO version of above.

8.6.9 Other Information Chronic Conditions

8.6.9.1 If the Plan would like to include additional information about helping members manage chronic conditions that was not reflected in this section, provide as CC 5.

Single, Pull-down list.
1: CC 5 is provided with a 4 page limit,
2: Not provided

8.7 PHARMACEUTICAL MANAGEMENT

8.7.1 Instructions and Definitions

8.7.1.1 Please note that specific instructions and definitions are provided and embedded into the appropriate question within each section and module. Refer to the "General Background and Process Directions" document for background, process and response instructions that apply across the 2014 eValue8 RFI. The "General Background and Process Directions" document should be routed to all Plan or Vendor personnel providing responses.

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

8.7.1.3 Pharmacy Benefit Manager is abbreviated as "PBM" throughout this form. **If the Plan contracts with a PBM, the Plan is strongly encouraged to work collaboratively with the PBM in the completion of this form.**

8.7.1.4 **All questions refer to the Plan's commercial membership. Membership of commercial customers that have removed pharmacy management from the Plan (carved-out) and directly contracted with a separate PBM should be excluded from all responses and calculations.**

8.7.1.5 All responses for the 2014 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2014 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

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

8.7.2 Value-Based Formulary

8.7.2.1 Has the Plan developed a “value-based” formulary for use by purchasers that ranks pharmaceuticals ACROSS DRUG CLASSES by clinical importance and effectiveness? (This is different from the Plan's decision process of the pharmacy and therapeutics committee to determine which drugs are placed on formulary. By this definition the Plan must have considered the relative criticality of drugs between drug classes and introduced copays or coinsurance designs that make some brand drugs available on the lowest cost tier for “essential” drug classes regardless of availability of generic and/or OTC medications to make substantial use of brand drugs necessary to accommodate member needs.). If the Plan has developed a value-based formulary as defined above, describe in the Detail text box the following: process and sources for determining its content and structure, the purchaser name(s) and the market if this is a pilot. If this was a pilot the previous year, please provide a brief update in detail box.

Single, Pull-down list.
1: Yes, and the ranking is tied to a variable copay design available in this market,
2: Yes, and the ranking is tied to a variable copay design being piloted,
3: Yes, but there is currently no link to a variable copay design,
4: An evidence-based formulary is under development,
5: No

8.7.3 Generic & Appropriate Drug Use

8.7.3.1 Does the Plan employ any of the following strategies (defined below) to address cost management or appropriateness of utilization?

Therapeutic class reference pricing defined as: assigning a maximum allowable cost for the lowest cost drug among therapeutically equivalent drugs. For therapeutic class MAC strategies, the member or physician group at risk, etc. would bear the cost differential of the higher priced drug, if he/she chose to ignore the lower cost recommendation.

Therapeutic Interchange: defined as substitution of therapeutically equivalent drugs at the point of service or in a subsequent refill after physician consultation.

Prior Authorization defined as a requirement that the Practitioner receive authorization from the Plan before the drug can be dispensed.

Step therapy is used in cases where there may be some patient-specific advantages to one brand drug compared to another or to a generic, and is defined as a requirement that the appropriate, usually less expensive drugs be tried first to determine efficacy before converting to a higher priced drug in the same class.

Dose Optimization defined as requiring that single dose-alternatives be used instead of multiple doses per day where single doses are possible.

Multi, Checkboxes.
1: Therapeutic Class reference Pricing,
2: Therapeutic Interchange,
3: Prior Authorization,
4: Step Therapy,
5: Dose Optimization,
6: Pill Splitting,
7: Mandatory mail order refills for chronic drug therapy after 2nd, 3rd or 4th fill of 30 day quantity at a community/retail pharmacy,
8: Partial fill dispensing for specialty medications with patient follow-up,
9: Other (describe in detail box below),
10: None of the Above

8.7.3.2 For HMO, provide the Plan's **aggregate generic dispensing** rate (% of total prescriptions that were filled with a generic drug, regardless of whether a generic was available), excluding injectables. The Plan should report the strict definition of "generic" provided by a nationally recognized and accepted source (i.e. First DataBank or Medispan). Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and **round up** to convert. For example, a 100 day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4). **If the Plan has a policy of covering prescription and/or OTC brand drugs where the generic drug is more expensive, indicate in the “Adj Answer” row the dispensing rate adding those fills to the numerator and denominator.**

HMO Response	2013 Percent for this market/state	2012 Percent for this market/state	2013 Percent for the nation	2012 Percent for the nation
Aggregate Generic Dispensing Rate	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Percent.* N/A OK. From 0 to 100.00.	*Percent.* N/A OK.
Adj Answer	*Percent.*	*Percent.*	*Percent.* N/A OK.	*Percent.* N/A OK.

8.7.3.3 PPO version of above.

8.7.3.4 For the HMO, provide the requested rates as defined below. Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round up to convert. For example, a 100 day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4).

HMO Response	Rx program in Market/State?	Market/State 2013 rate	Market/State 2012 rate	Rx program in nation?	Statewide 2013 rate	Statewide 2012 rate
Generic ACE inhibitors (ACE and ACE with HCTZ)/(ACE + ARBs (angiotensin II receptor antagonists)) Include ACE and ARB drugs that are dispensed as combination drugs in the denominator (i.e., ACE, ACE combinations (HCTZ or other agents), ARB and ARB combinations (HCTZ or other agents))	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.
Generic PPIs +OTC PPIs / (All PPIs INCLUDING OTC PPIs)	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.
Generic STATINS/(ALL Cholesterol lowering agents) Cholesterol lowering agents : statins (and statin combinations e.g., atoravastatin/amlodipine combination), bile acid binding resins (e.g., cholestyramine, colestipol and colesevelam), cholesterol absorption inhibitors and combinations (ezetimibe and ezetimibe/simvastatin),fibrates (fenofibrate and gemfibrozil), Niacin (vitamin B-3, nicotinic acid) and niacin/lovastatin combination. IF ezetimibe/simvastatin is counted in statin combination - DO NOT COUNT again under ezetimibe combination.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.*	*Single, Radio group.* 1: Yes, 2: No	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.
Generic metformin/all oral anti diabetics, including all forms of glucophage	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.
Generic SSRIs/all SSRI antidepressants	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* N/A OK. From 0 to 100.	*Percent.* N/A OK.

8.7.3.5 PPO version of above.

8.7.3.6 Review the overall rate of antibiotic utilization from HEDIS QC 2013. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'

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

Please refer to the attached document for an explanation of terms

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

	QC 2013 (HMO)
Average number of antibiotic scripts PMPY	*Decimal.*
Average days supplied per antibiotic script	*Decimal.*
Average number of scripts PMPY for antibiotics of concern	*Decimal.* From -10 to 100.
Percentage of antibiotics of concern out of all antibiotic scripts	*Percent.* From -10 to 100.

8.7.3.7 PPO version of above.

8.7.4 Specialty Pharmaceuticals

8.7.4.1 Purchasers have an increasing interest in the prevalence of use and cost of specialty medications and biologics. (See attached list defining specialty pharmaceuticals (SP) and formulations for use in this section). If any drugs on the attached list are not addressed in your program, list them in the "detail description" text box and indicate why they are not included.

For total spend in calendar year 2013,and **using only the specialty pharmaceuticals (SPs) in the attached list,** please provide **estimates** of the percent spent on SPs (versus overall), self-administered medications, and percent reimbursed through the medical benefit. Describe below the plan's (1) current strategy, activities and programs implemented to manage specialty pharmaceuticals & biologics in 2013. (2) Please outline any changes planned for **2014.** (3) If plan uses a specialty vendor, please describe their strategy and provide their name.

Does plan use a specialty vendor? If yes provide name	*50 words.*
Estimate the % of specialty drug spend out of all drug spend (denominator = total $ drug spend including specialty drug $)	*Percent.* N/A OK. From 0 to 100.
Estimate the % of specialty pharmacy drug spend that is reimbursed under the medical benefit	*Percent.* N/A OK. From 0 to 100.
Estimate the % of specialty drug spend that is self-administered	*Percent.* N/A OK. From 0 to 100.
Current strategy, activities or programs to manage specialty medicines and biologics	*200 words.*
Changes planned in following year	*100 words.*

8.7.4.2 Indicate if the Plan implemented one or more of the following programs to address specialty pharmaceuticals (SP) defined in attached list in 7.4.1. Check all that apply.

Program (Specialty Pharmaceuticals)	Answer	Describe Program (and tiering)
Use of formulary tiers or preferred/non-preferred status (if yes, please describe in last column what tier or status you typically use for the drugs listed)	*Single, Radio group.* 1: Yes, 2: No	*65 words.*
Utilization Management		

Prior authorization	AS ABOVE	AS ABOVE
Step edits	AS ABOVE	AS ABOVE
Quantity edits/limits	AS ABOVE	AS ABOVE
Limits on off label use	AS ABOVE	AS ABOVE
Split fill (Specialty Pharmacy sends 14 Day quantity, then checks up on patients side effects, adherence, and sends another 14 days –at least for the 1ST month)	AS ABOVE	AS ABOVE
Use of Genomic Test to assess appropriateness or effectiveness of medication in particular patient	AS ABOVE	AS ABOVE
Channel Management (limiting dispensing to specific providers)	AS ABOVE	AS ABOVE
Reimbursement Reductions (reimbursing physicians, PBM, pharmacies according to a fixed fee schedule)	AS ABOVE	AS ABOVE
None of the above	AS ABOVE	

8.7.4.3 Does the Plan allow an employer the option to allow physician administered products to be delivered via the pharmacy benefit versus medical benefit? If YES, please detail below how Plan would do this for chemotherapy administered directly by physicians

Single, Radio group.
1: Yes,
2: No

8.7.4.4 For the listed conditions associated with SP drugs, indicate how these conditions are managed.

Condition	Management	Details (description of “other” or the main condition)
Rheumatoid Arthritis	*Multi, Checkboxes.* 1: Managed by DM/ Care management program if it is the sole condition, 2: Managed by DM/ Care management program only if a comorbidity with another condition (e.g. diabetes), (name the condition in the next column), 3: Internally Managed as part of SP program independent of the DM/ Care management program, 4: Managed by SP vendor independent of the DM/ Care management program, 5: Member compliance with SP drugs is monitored through refill claims and made available to care managers, 6: Not managed by either DM or SP program, 7: Integrated and managed as part of patient centered care (describe), 8: Other (describe in next column)	*65 words.*
Multiple Sclerosis	AS ABOVE	AS ABOVE
Oncology	AS ABOVE	AS ABOVE
Hepatitis C	AS ABOVE	AS ABOVE
HIV	AS ABOVE	AS ABOVE
Hemophilia	AS ABOVE	AS ABOVE
Growth Hormone Deficiency	AS ABOVE	AS ABOVE

8.7.4.5 Using only the drugs identified in the list attached to question 7.4.1 and their condition associations (e.g. hepatitis C), for your total commercial book of business, provide the TOTAL cost per member per month (PMPM) for SP/biotech pharmaceuticals **including acquisition, administration fees and member copayments BUT net of rebates, and discounts.**

Drug Class	2013 PMPM Cost	2012 PMPM Cost

TNF Inhibitors	*Dollars.* N/A OK. From 0 to 1000000000.	*Dollars.* N/A OK.
ESAs excluding dialysis medications	AS ABOVE	AS ABOVE
WBC Growth Factors	AS ABOVE	AS ABOVE
MS Drug Therapies	AS ABOVE	AS ABOVE
Hepatitis C Drug Therapies	AS ABOVE	AS ABOVE
Oral oncolitics	AS ABOVE	AS ABOVE
Office-administered drugs	AS ABOVE	AS ABOVE
ALL the drugs in the SP list	AS ABOVE	AS ABOVE

8.7.5 Quality and Safety: Outpatient Prescribing

8.7.5.1 Review HEDIS scores for the indicators listed.

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

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

Please refer to the attached document for an explanation of terms

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

	HEDIS QC 2013 (HMO)	HEDIS QC 2012 (HMO)
Appropriate treatment for children with upper respiratory infection	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Appropriate testing for children with pharyngitis	AS ABOVE	AS ABOVE
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	AS ABOVE	AS ABOVE
Use of Appropriate Medications for People with Asthma - Total	AS ABOVE	AS ABOVE
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Digoxin	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Diuretics	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Total	AS ABOVE	AS ABOVE

8.7.5.2 PPO version of above.

8.7.5.3 For persons with asthma on medication therapy, purchasers expect plans to monitor and identify those who are not controlled optimally and/or not on controller therapy. Please see the attachment for the Pharmacy Quality Alliance (PQA) approved definitions to respond to question on

suboptimal control and absence of controller therapy (pages 4, 8, 30-32). The NDCs list excel workbook attachment can be found in "Manage Documents": NDC List 6_28_2013 NBCH Customized. Please refer to the "Respiratory" tab in the excel document.

This question is flagged "Regional." Statewide carriers - if plan provided a statewide response - please note this in detail box below.

Description	Rate (HMO regional Response)	Rate (PPO Regional Response)
Suboptimal Control: The percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.	*Percent.* N/A OK. From -10 to 100.	*Percent.* N/A OK. From -10 to 100.
Absence of Controller Therapy: The percentage of patients with asthma during the measurement period who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.	*Percent.* N/A OK. From -10 to 100.	*Percent.* N/A OK. From -10 to 100.

8.7.6 Other Information

8.7.6.1 If the Plan would like to provide additional information about the pharmacy program that was not reflected in this section, provide as Attachment Pharmacy 1.

Pharmacy 1 is provided.

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

8.8 Client Support, Data Analyses and Reporting

8.8.1 Beneficiary Communication and Benefit Design

8.8.1.1 Indicate the beneficiary communication and outreach support offered to the Plan's Purchaser customers. ***For programs, address communication about the existence of member support tools and how to access and use them, not the communication that takes place within each program.***

Examples of on-site services include member enrollment support or product demonstrations at employee health fairs or open enrollment meetings. Check all that apply. "Pharmaceutical decision support information" is meant to indicate ongoing member support services such as online information (e.g., drug dictionaries, generic equivalents, etc.), general information mailings or targeted member mailings, (e.g., targeted mailings to members who may be taking a brand drug that is coming off-patent identifying available alternatives).

Program area	Type of support (for fully insured lives/plan)	Type of support (for self insured lives/plan)
Prevention/health/wellness materials that include content about those preventive services (e.g., cancer screenings, immunizations) that are available to beneficiaries with $0 cost share under the ACA	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available
Prevention/health/wellness biometric testing	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Support not available	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Support not available
Chronic condition management program information	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee,	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee,

	4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available	4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available
Practitioner/Hospital selection/comparison information	AS ABOVE	AS ABOVE
Pharmaceutical decision support information	AS ABOVE	AS ABOVE
Treatment option decision support information	AS ABOVE	AS ABOVE
Personal health record information	AS ABOVE	AS ABOVE
Price comparison information	AS ABOVE	AS ABOVE
Engaging employees to access PCP, PCMH and/or ACO Providers	AS ABOVE	AS ABOVE
Engaging employees with limited English	AS ABOVE	AS ABOVE
Engaging employees of particular cultural groups	AS ABOVE	AS ABOVE
Engaging employees with limited health literacy	AS ABOVE	AS ABOVE

8.8.1.2 Evidence is emerging that suggests better alignment of consumer incentives through plan design will result in improved plan performance. Examples of this type of alignment include removal or reduction of financial barriers to essential treatments, using comparative evidence analysis to provide a graded scale of copays reflecting the importance/impact of specific treatments, premium reduction or other incentives for members that use higher performing providers (physicians and hospitals), or follow preventive and/or chronic disease management guidelines, etc.

Please describe any efforts that the Plan is currently undertaking or planning for the future. List any limitations **in this market** on the geographic availability of pilots, incentive designs or high performance networks.

200 words.

8.8.2 Data Analyses and Reporting

8.8.2.1 For the book of business represented by this RFI response and supported by the attachment(s) labeled as Client 1 in question below, indicate (1) the types of data analyses and reporting available to employers and/or their designated vendors on health management and chronic conditions, and (2) the sources of data used to generate the types of analyses and reports available to Employers. Purchasers expect plans to help assess and improve health status of their Employees using a variety of sources. Check all that apply. **If reports are not part of the standard premium or ASO fee, plans should also select response that says** "Report available for additional fee."

	Report Features for Fully Insured Lives/Plan	Report Features for Self Insured Lives/Plan	Sources of Data
Chronic Condition Prevalence	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 5: Trend comparison of two years data – fixed Jan-Dec annual reporting, 6: All of the above reports integrated into single report, 7: Report available for additional fee, 8: Data/reporting not available	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 5: Trend comparison of two years data – fixed Jan-Dec annual reporting, 6: All of the above reports integrated into single report, 7: Report available for additional fee, 8: Data/reporting not available	*Multi, Checkboxes.* 1: HRAs, 2: Medical Claims Data, 3: Pharmacy Claims Data, 4: Lab Values, 5: Other source - please detail below
Employee	AS ABOVE	AS ABOVE	AS ABOVE

Population stratified by Risk and/or Risk Factors			
Chronic Condition/Disease Management (DM) program enrollment	AS ABOVE	AS ABOVE	AS ABOVE
Change in compliance among DM enrollees (needed tests, drug adherence)	AS ABOVE	AS ABOVE	AS ABOVE
Health status change among DM enrollees	AS ABOVE	AS ABOVE	AS ABOVE

8.8.2.2 Attachments are needed to support plan responses to the question above. Provide as Client 1, blinded samples of standard purchaser report(s) for:

A) chronic condition prevalence OR management,
B) population risk stratification, and
C) changes in compliance OR health status

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

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

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

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

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

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

Single, Radio group.
1: Client 1 is provided,
2: Not provided

9. SHOP SUPPLEMENTAL APPLICATION

9.1 Applicant must identify the individual(s) who will function as the Exchange's primary contact for SHOP products.

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

9.2 In addition to standardized benefit design products, the Applicant may submit one (1) alternate benefit design product for the rating region. The alternate benefit design must be offered at the silver level but is not required to be offered at all metal levels; any alternate benefit design must represent a product family using the same network across all actuarial values. Use Attachment F SHOP Alternate Plan Design to submit all cost-sharing and other details for proposed alternate benefit plan designs. The Exchange is not necessarily encouraging alternate benefit plan designs and will carefully scrutinize such proposals.

☐ Yes, completed Attachment F to indicate benefits and cost-sharing for each alternate benefit design proposed

☐ No, not proposing alternate benefit design

If yes, Attachment F SHOP Alternate Plan Design to indicate benefits and member cost sharing design for each alternate benefit plan design you propose. In completing the matrix, Applicant may insert text to:

- Indicate any additional or enhanced benefits relative to EHB
- Confirm all plans include pediatric oral and vision EHB
- If in-network tiers are proposed, describe the structure for hospital or provider tiers.

9.3 Preliminary Premium Proposals: Final negotiated and accepted premium proposals shall be in effect for the 12 month period subsequent to the initial effective dates for all employer groups whose initial effective dates are between January 1, 2015 and December 31, 2015. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies in conjunction. Premium bids are due May 1, 2014. To submit premium proposals for SHOP products, QHP applicants will complete and upload through the System for Electronic Rate and Form Filing (SERFF) the Unified Rate Review Template (URRT) and the Rates Template located at: http://www.serff.com/plan_management_data_templates.htm. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level.

Applicant shall provide, upon the Exchange's request, in connection with any negotiation process as reasonably requested by the Exchange, detailed documentation on the Exchange-specific rate development methodology. Applicant shall provide justification, documentation and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions and other information that affects the Exchange specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Exchange-specific account.

9.4 **Agent Relations, Fees and Commissions**

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

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

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

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

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

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

9.5. Quality Improvement

9.5.1 Complete the following table to provide additional detail regarding member incentives available in SHOP Exchange.

Preventive and Wellness Services	**Available in SHOP Exchange**	**SHOP Exchange Financial Incentives**	**SHOP Exchange Financial Incentives**
Incentives Contingent	*Yes/No*	*Yes/No*	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced employee premium share and increased employer premium share contingent upon completion/participation. Health Plan premium rates remain unchanged, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported
Health Assessment Offered	AS ABOVE	AS ABOVE	
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	
Tobacco Cessation Program	AS ABOVE	AS ABOVE	
Wellness Goals Other than	AS ABOVE	AS ABOVE	

Weight-Loss and Tobacco Cessation: Stress Management			
Wellness Goals Other than Weight-Loss and Tobacco Cessation: Mental Health	AS ABOVE	AS ABOVE	
OTHER	AS ABOVE	AS ABOVE	

Appendix A: Definition of Good Standing

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

[1]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Model QHP Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

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

2. Definitions.

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

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

3. Description of Provider.

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

/_/ The IHS.

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

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

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

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

4. Persons Eligible for Items and Services from Provider.

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

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

5. Applicability of Other Federal Laws.

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

(a) The IHS as a Provider:

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

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

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

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

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

6. Non-Taxable Entity.

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

7. Insurance and Indemnification.

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

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

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

8. Licensure of Health Care Professionals.

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

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

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

9. Licensure of Provider; Eligibility for Payments.

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

10. Dispute Resolution.

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

11. Governing Law.

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

12. Medical Quality Assurance Requirements.

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

13. Claims Format.

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

14. Payment of Claims.

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

15. Hours and Days of Service.

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

16. Contract Health Service Referral Requirements

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

17. Sovereign Immunity.

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

18. Endorsement.

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

APPROVALS

For the Qualified Health Plan Issuer:	**For the Provider:**
_____	_____
Date _____	Date _____

Appendix C Census Tract Data on California Low-Income Population

County-Level Data on Distribution of California Low-Income Population (defined as a family at or below 200% of poverty). **This data is supplied in electronic spreadsheet format. County-Level Data on Distribution of California Low-Income Population**
http://www.healthexchange.ca.gov/Solicitations/Documents/Tract_Poverty.xls

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment A - Regulatory Filings

Issuer Name:

Instructions:
Please provide the requested details associated with any Regulatory and/or Product filings necessary to obtain approval of products/plans that are to be submitted in response to this application.

Type of Filing	Regulatory Agency	Regulatory Filing Number (if applicable)	Product Filing Number (if applicable)	Date of Submission	Expected Date for Review / Approval	Amendment Number (if, applicable)	Initial Filing Date (If applicable)	Comments
	DOI							

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment B1- Plan Type by Rating Region (Individual)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

INDIVIDUAL								
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 1	Alpine							
Region 1	Del Norte							
Region 1	Siskiyou							
Region 1	Modoc							
Region 1	Lassen							
Region 1	Shasta							
Region 1	Trinity							
Region 1	Humboldt							
Region 1	Tehama							
Region 1	Plumas							
Region 1	Nevada							
Region 1	Sierra							
Region 1	Mendocino							
Region 1	Lake							
Region 1	Butte							
Region 1	Glenn							
Region 1	Sutter							
Region 1	Yuba							
Region 1	Colusa							
Region 1	Amador							
Region 1	Calaveras							
Region 1	Tuolumne							
Region 2	Napa							
Region 2	Sonoma							

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan
Region 2	Solano							
Region 2	Marin							
Region 3	Sacramento							
Region 3	Placer							
Region 3	El Dorado							
Region 3	Yolo							
Region 4	San Francisco							
Region 5	Contra Costa							
Region 6	Alameda							
Region 7	Santa Clara							
Region 8	San Mateo							
Region 9	Santa Cruz							
Region 9	Monterey							
Region 9	San Benito							
Region 10	San Joaquin							
Region 10	Stanislaus							
Region 10	Merced							
Region 10	Mariposa							
Region 10	Tulare							
Region 11	Fresno							
Region 11	Kings							
Region 11	Madera							
Region 12	San Luis Obispo							
Region 12	Ventura							
Region 12	Santa Barbara							
Region 13	Mono							
Region 13	Inyo							
Region 13	Imperial							
Region 14	Kern							
Region 15	Los Angeles							
Region 16	Los Angeles							
Region 17	San Bernardino							
Region 17	Riverside							
Region 18	Orange							
Region 19	San Diego							

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment B2 - Plan Type by Rating Region (SHOP)

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan or propose an Alternate Plan. The 19 regions, shown below, are defined based on recent California legislation. Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels.

SHOP										
Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 1	Alpine									
Region 1	Del Norte									
Region 1	Siskiyou									
Region 1	Modoc									
Region 1	Lassen									
Region 1	Shasta									
Region 1	Trinity									
Region 1	Humboldt									
Region 1	Tehama									
Region 1	Plumas									
Region 1	Nevada									
Region 1	Sierra									
Region 1	Mendocino									
Region 1	Lake									
Region 1	Butte									
Region 1	Glenn									
Region 1	Sutter									
Region 1	Yuba									
Region 1	Colusa									
Region 1	Amador									
Region 1	Calaveras									
Region 1	Tuolumne									
Region 2	Napa									
Region 2	Sonoma									
Region 2	Solano									
Region 2	Marin									
Region 3	Sacramento									
Region 3	Placer									
Region 3	El Dorado									

Rating Region	County	Partial County Yes/No	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan	Catastrophic Plan	HSA Bronze Plan	HSA Silver Plan	Alternate Plan
Region 3	Yolo									
Region 4	San Francisco									
Region 5	Contra Costa									
Region 6	Alameda									
Region 7	Santa Clara									
Region 8	San Mateo									
Region 9	Santa Cruz									
Region 9	Monterey									
Region 9	San Benito									
Region 10	San Joaquin									
Region 10	Stanislaus									
Region 10	Merced									
Region 10	Mariposa									
Region 10	Tulare									
Region 11	Fresno									
Region 11	Kings									
Region 11	Madera									
Region 12	San Luis Obispo									
Region 12	Ventura									
Region 12	Santa Barbara									
Region 13	Mono									
Region 13	Inyo									
Region 13	Imperial									
Region 14	Kern									
Region 15	Los Angeles									
Region 16	Los Angeles									
Region 17	San Bernardino									
Region 17	Riverside									
Region 18	Orange									
Region 19	San Diego									

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment C - QHP 2015 Enrollment Projections

Issuer Name:
Product:
Market:

Please complete Attachment C enrollment projection for each product and market type. Enrollment projection should reflect anticipated enrollment January 1, 2015 through December 1, 2015

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 1	Alpine		
Region 1	Del Norte		
Region 1	Siskiyou		
Region 1	Modoc		
Region 1	Lassen		
Region 1	Shasta		
Region 1	Trinity		
Region 1	Humboldt		
Region 1	Tehama		
Region 1	Plumas		
Region 1	Nevada		
Region 1	Sierra		
Region 1	Mendocino		
Region 1	Lake		
Region 1	Butte		
Region 1	Glenn		
Region 1	Sutter		
Region 1	Yuba		
Region 1	Colusa		
Region 1	Amador		
Region 1	Calaveras		
Region 1	Tuolumne		
Region 2	Napa		
Region 2	Sonoma		
Region 2	Solano		
Region 2	Marin		
Region 3	Sacramento		
Region 3	Placer		
Region 3	El Dorado		
Region 3	Yolo		
Region 4	San Francisco		
Region 5	Contra Costa		
Region 6	Alameda		
Region 7	Santa Clara		
Region 8	San Mateo		
Region 9	Santa Cruz		
Region 9	Monterey		
Region 9	San Benito		
Region 10	San Joaquin		
Region 10	Stanislaus		

Rating Region	County	Product (HMO/EPO/PPO)	2015 Enrollment Projections
Region 10	Merced		
Region 10	Mariposa		
Region 10	Tulare		
Region 11	Fresno		
Region 11	Kings		
Region 11	Madera		
Region 12	San Luis Obispo		
Region 12	Ventura		
Region 12	Santa Barbara		
Region 13	Mono		
Region 13	Inyo		
Region 13	Imperial		
Region 14	Kern		
Region 15	Los Angeles		
Region 16	Los Angeles		
Region 17	San Bernardino		
Region 17	Riverside		
Region 18	Orange		
Region 19	San Diego		

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment D1 - Delivery System Reform (Individual)

Indicate the geography and contracted providers engaged in delivery system initiatives, and expected availability for the Individual Exchange enrollees. The 19 regions are defined based on recent California legislation and shown in the linked attachment. For the columns indicating the number of members and physicians included, report data as of January 1, 2014; if current data are not available, report data as of September 30, 2013.

Rating Region	Type of Initiative *(see definitions below)	Geographic Availability	Product Availability	List partner organizations (medical groups and hospitals)	Number of members included in the program	Number of primary care physicians included in the program	Number of specialists included in the program
	Multi, Choice Accountable Care Organization Primary Care Medical Home	*Single, Pull-down list* Full Region Partial Region Not Offered	*Single, Pull-down list* Available to the Exchange in 2015 Not Available to the Exchange May be available to the Exchange after 2015	*Detail box 500 words*	*Numeric*	*Numeric*	*Numeric*
Region 1							
Region 2							
Region 3							
Region 4							
Region 5							
Region 6							
Region 7							
Region 8							
Region 9							
Region 10							
Region 11							
Region 12							
Region 13							
Region 14							
Region 15							
Region 16							
Region 17							
Region 18							
Region 19							

*Accountable Care Organizations means that there is both upside and downside risk for participants with gainsharing available to purchasers or consumers
*Primary Care Medical Home means a targeted effort to support practice transformation and steerage of members to PCMH-designated providers

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment D2 - Delivery System Reform (SHOP)

Indicate the geography and contracted providers engaged in delivery system initiatives, and expected availability for the SHOP Exchange enrollees. The 19 regions are defined based on recent California legislation and shown in the linked attachment. For the columns indicating the number of members and physicians included, report data as of January 1, 2014; if current data are not available, report data as of September 30, 2013.

Rating Region	Type of Initiative *(see definitions below)	Geographic Availability	Product Availability	List partner organizations (medical groups and hospitals)	Number of members included in the program	Number of primary care physicians included in the program	Number of specialists included in the program
	Multi, Choice Accountable Care Organization Primary Care Medical Home	*Single, Pull-down list* Full Region Partial Region Not Offered	*Single, Pull-down list* Available to the Exchange in 2015 Not Available to the Exchange May be available to the Exchange after 2015	*Detail box 500 words*	*Numeric*	*Numeric*	*Numeric*
Region 1							
Region 2							
Region 3							
Region 4							
Region 5							
Region 6							
Region 7							
Region 8							
Region 9							
Region 10							
Region 11							
Region 12							
Region 13							
Region 14							
Region 15							
Region 16							
Region 17							
Region 18							
Region 19							

*Accountable Care Organizations means that there is both upside and downside risk for participants with gainsharing available to purchasers or consumers
*Primary Care Medical Home means a targeted effort to support practice transformation and steerage of members to PCMH-designated providers

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment E1 - Contracted Providers by County as of 1-1-14

Using the following format, attach a list of the Applicant's contracted provider network.

Variable Name	Description	Type	Length
PROV_ID	Plan-assigned Provider number	Chr	20
PROV_FNAME	Provider First Name	Chr	20
PROV-MI	Provider Middle Initial	Chr	6
PROV_LNAME	Provider Last Name	Chr	30
PROV_SUFFIX	Provider Degrees (MD, DO, NP, LSW etc)	Chr	20
PROV_ORG	Medical Group or Community Health Center Name	Chr	40
DMHC_ID	DMHC number for Medical Group	Chr	10
PROV_SUB_NAME	Entity Sub-Division Name	Chr	30
PROV_ADDR	Entity Street Address	Chr	30
PROV_ADDR2	2nd address line, if needed	Chr	30
PROV_CITY	Entity City	Chr	20
PROV_ZIP	Entity Zipcode	Chr	10
PROV_COUNTY	Entity County	Chr	20
340B_ID	340B Provider ID	Chr	35
NPI	National Provider ID	Chr	20
LICENSE #	License Number	Chr	25
TYPE_CODE	Entity Type Code	Chr	37
PRIMARY_CARE	Y/N If provider is a primary care provider	Chr	1
PRACTICE_OPEN	Y/N if provider is accepting new patients	Chr	1
HMO CONTRACT FLAG	Y/N	Chr	1
PPO CONTRACT FLAG	Y/N	Chr	1
ACO CONTRACT FLAG	Y/N	Chr	1
PCMH Certified	Y/N	Chr	1
NARROW NETWORK CONTRACT	Y/N	Chr	1
TRIBAL_URBAN_INDIAN	Y/N if provider is a federally designated 638 Tribal Health Programs or Title V Urban Indian Health Organization*	Chr	1
SCHOOL_CLN	Y/N if provider is a full-service school-based clinic*	Chr	1
FQHC	Y/N if Federally Qualified Health Center*	Chr	1
MCAL_EHR	Y/N if Provider has approved application for the HI-TECH Medi-Cal Electronic Health Record Incentive Program*	Chr	1
1204a	Y/N if Provider is licensed as either a “community clinic or “free clinic”, under the California Health and Safety Code section 1204(a) and (2), or is a community clinic or free clinic exempt from licensure under Section 1206*	Chr	1
HIGH_PERF_FLAG	Y/N If Issuer uses a quality designation program, indicate if the provider has a quality designation	Chr	1
MCAL_MGD_CARE	Y/N If Plan contracts with both commercial and Medi-Cal Managed Care, indicate if the provider is available in the Medi-Cal Managed Care Network	Chr	1
STD_PLAN_1	Y/N If provider is in the network supporting Exchange Standard Plan 1	Chr	1
STD_PLAN_2	Y/N If provider is in the network supporting Exchange Standard Plan 2	Chr	1
Alt Plan Contract Flag	Y/N If Issuer is submitting an Alternate Plan design, indicate if this provider is part of that network	Chr	1
PATIENT_VOL	If provider is a primary care provider, number of patients currently assigned, if PCP offered through HMO Product	Num	4

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment E2 - Contracted Facilities by County as of 1-1-14

Using the following format, attach a list of the Applicant's contracted facility network.

Variable Name	Description	Type	Length
HOSP_ID	Plan-assigned ID number	Chr	20
ORG	Facility Name	Chr	40
ADDR	Entity Street Address	Chr	30
ADDR2	Address line 2 (if needed)	Chr	30
CITY	Entity City	Chr	20
ZIP	Entity Zipcode	Chr	10
COUNTY	Entity County	Chr	20
340B_ID	340B Provider ID	Chr	35
DSH	Y/N if Disproportionate Share Status	Chr	20
LICENSE #	License Number	Chr	20
HMO CONTRACT FLAG	Y/N	Chr	1
PPO CONTRACT FLAG	Y/N	Chr	1
ACO CONTRACT FLAG	Y/N	Chr	1
NARROW NETWORK CONTRACT	Y/N	Chr	1
HIGH_PERF_FLAG	Y/N If Issuer uses a quality designation program, indicate if the facility has a quality designation	Chr	1
MCAL_MGD_CARE	Y/N If Plan contracts with both commercial and Medi-Cal Managed Care, indicate if the facility is available in the Medi-Cal Managed Care Network	Chr	1
STD_PLAN_1	Y/N If facility is in the network supporting Exchange Standard Plan 1	Chr	1
STD_PLAN_2	Y/N If facility is in the network supporting Exchange Standard Plan 2	Chr	1
Alt Plan Contract Flag	Y/N If Issuer is submitting an Alternate Plan design, indicate if this facility is part of that network	Chr	1

California Health Benefit Exchange
2015 QHP New Entrant Application
Attachment F SHOP Alternate Plan Design

Input the cost sharing amounts that describe the enrollee's out-of-pocket costs for each benefit category. List any exclusions in the column on the right.
Applicant is offering a Standard
Plan across all metal levels.
Yes
No

		Silver Alternate Plan	Silver Alternate Plan	Platinum Alternate Plan (Optional)	Platinum Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Provide additional detail including any exclusions
		Single pull-down list Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	
		Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	
12/28/2012										
Estimated Actuarial Value		%	%	%	%	%	%	%	%	
Overall deductible		$	$	$	$	$	$	$	$	
Other deductibles for specific services		$	$	$	$	$	$	$	$	
Facility-related Services		$	$	$	$	$	$	$	$	
Brand Drugs		$	$	$	$	$	$	$	$	
Dental		$	$	$	$	$	$	$	$	
Out–of–pocket limit on expenses		$	$	$	$	$	$	$	$	
Service Type	**Professional/ Hospital**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Provide additional detail including any exclusions**
Visit to a health care provider's office or clinic										
Primary care visit to treat an injury or illness (*deductible waived for first visit except Non-Par Providers or HSA plans--see footnote*)		Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	*text box, 100 words - replicate below*
Specialist visit		Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	
Other practitioner office visit										
Preventive care/ screening/ immunization										
Tests										
Diagnostic test (x-ray, blood work)										
Imaging (CT/PET scans, MRIs)										
Drugs to treat illness or condition										
Generic drugs										
Preferred brand drugs										
Non-preferred brand drugs										
Specialty drugs										
Outpatient surgery										
Facility fee (e.g., ambulatory surgery center)										

		Silver Alternate Plan	Silver Alternate Plan	Platinum Alternate Plan (Optional)	Platinum Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Provide additional detail including any exclusions
		Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	
Physician/surgeon fees										
Need immediate attention										
Emergency room services										
Emergency medical transportation										
Urgent care										
Hospital stay										
Facility fee (e.g., hospital room)										
Physician/surgeon fee										
Mental health, behavioral health, or substance abuse needs										
Mental/Behavioral health outpatient services										
Mental/Behavioral health inpatient services										
Substance use disorder outpatient services										
Substance use disorder inpatient services										
Pregnancy										
Prenatal and postnatal care										
Delivery and all inpatient services	Professional									
Delivery and all inpatient services	Hospital									
Help recovering or other special health needs										
Home health care										
Rehabilitation services										
Habilitation services										
Skilled nursing care										
Durable medical equipment										
Hospice service										
Child needs dental or eye care										
Eye exam (*deductible waived*)										
Glasses										
Dental check-up - Preventive and Diagnostic Services (*deductible waived*)										
Dental Basic Services										
Dental Restorative and Orthodontia Services										

Authority: Government Code Section 100504, 100505

Reference Government Code Sections 100502, 100503,100504,100505