COVERED CALIFORNIA
QUALIFIED HEALTH PLAN CONTRACT FOR 2014
between

Covered California, the California Health Benefit Exchange
and
_____ ("Contractor")

List of Attachments to Qualified Health Plan Model Contract, Final Staff Recommendations, May 6, 2013

Attachment 1 Contractor's Qualified Health Plan List
Attachment 2 Benefit Plan Designs
Attachment 3 Good Standing
Attachment 4 Service Area Listing
Attachment 5 Provider Agreement - Standard Terms
Attachment 6 Customer Service Standards
Attachment 7 Quality, Network Management and Delivery System Standards
Attachment 8 Monthly Rates - Individual Exchange
Attachment 9 Rate Updates - Individual Exchange
Attachment 10 Monthly Rates - SHOP
Attachment 11 Rate Updates - SHOP
Attachment 12 Participation Fee Methodology - Individual Exchange
Attachment 13 Participation Fee Methodology - SHOP
Attachment 14 Performance Measurement Standards
Attachment 15 Business Associate Agreement

Attachment 1. Contractor's QHP List [to be attached specifically for each Issuer]

Attachment 2. Benefit Plan Designs [to be attached specifically for each Issuer]

Attachment 3. Good Standing

Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
Approved for applicable lines of business (e.g. commercial, small group, individual)	DMHC
Approved to operate in what geographic service areas	DMHC
Most recent financial exam and medical survey report	DMHC
Most recent market conduct exam	CDI
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, in the prior year in relation to any of the following, where applicable:	
Financial solvency and reserves	DMHC and CDI
Administrative and organizational capacity	DMHC
Benefit design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential Health Benefits (as of 2014)	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (classification of metal level as of 2014)	DMHC and CDI
Network adequacy and accessibility standards	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 (as of 2014)	DMHC and CDI
Rating factors	DMHC and CDI
Medical loss ratio	DMHC and CDI
Premium rate review	DMHC and CDI
• Geographic rating regions	DMHC and CDI
• Rate development and justification is consistent with the Affordable Care Act requirements	
• Reasonableness review	

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

Attachment 4. Service Area Listing [to be attached specifically for each Issuer]

Attachment 5. Provider Agreement - Standard Terms

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

1. Provision of Covered Services. Contractor shall require each Participating Provider to assure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in the Agreement, as mutually agreed upon by the Exchange and Contractor, and which may include the following:

- Coordination with the Exchange and other programs and stakeholders (Section 1.06);
- Relationship of the parties as independent contractors (Section 1.08(a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.08(b));
- Participating Provider directory requirements (Section 3.05(c));
- Implementation of processes to enhance stability and minimize disruption to provider network (Section 3.05(d) and (e));
- Notice, network requirements and other obligations relating to costs of out-of-network and other benefits (Section 3.15);
- Credentialing, including, maintenance of licensure and insurance (Section 3.16);
- Customer service standards (Section 3.18);
- Utilization review and appeal processes (Section 3.17);
- Maintenance of a corporate compliance program (Section 3.19);
- Enrollment and eligibility determinations and collection practices (Sections 3.20 to 3.26);
- Appeals and grievances (Section 3.27);
- Enrollee and marketing materials (Section 3.28);
- Disclosure of information required by the Exchange, including, financial and clinical (Section 3.32; Quality, Network Management and Delivery System Standards (Article 4) and other data, books and records (Article 10));
- Nondiscrimination (Section 3.33);
- Conflict of interest and integrity (Section 3.34);
- Other laws (Section 3.35);
- Quality, Network Management and Delivery System Standards to the extent applicable to Participating Providers (Article 4), including, disclosure of contracting arrangements with Participating Providers as required under Attachment 7, Section 7.01 of the Quality, Network Management and Delivery System Standards;
- Performance Measures, to the extent applicable to Participating Providers (Article 6);

- Continuity of care, coordination and cooperation upon termination of Agreement and transition of Enrollees (Article 7);
- Security and privacy requirements, including compliance with HIPAA (Article 9); and
- Maintenance of books and records (Article 10).

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

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

Attachment 6. Customer Service Standards

Customer Service Standards

1. Customer Service Call Center.

(a) During Open Enrollment Period, call center hours shall be Monday through Saturday eight o'clock (8:00) a.m. to eight o'clock (8:00) p.m. (Pacific Standard Time). During non-Open Enrollment periods, call center hours shall be Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time) and Contractors shall inform the Exchange of additional call center hours their service centers are open.

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

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

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

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

2. Customer Service Transfers.

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

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

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

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

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

3. Customer Care.

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

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

4. Notices.

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

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

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

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

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

5. Issuer-Specific Information.

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

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

6. Enrollee Materials.

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

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

(i) Welcome letters

(ii) Enrollee ID card

(iii) Billing notices and statements

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

(v) Termination Grievance process materials

(vi) Drug formulary information

(vii) Uniform summary of benefits and coverage

(viii) Other materials required by the Exchange.

(c) New Enrollee Enrollment Packets.

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

(a) Welcome letter;

(b) Enrollee ID card;

(c) Summary of Benefits and Coverage;

(d) Pharmacy benefit information;

(e) Nurse advice line information; and

(f) Other materials required by the Exchange.

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

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

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

(f) Enrollee Identification Card. No later than 10 business days after receiving enrollment information from the Exchange, Contractor shall distribute to each Enrollee an identification card in a form that is approved by the Exchange.

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

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

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

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

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

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

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

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

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

7. Standard Reports. Contractor shall submit standard reports as described below, pursuant to timelines, periodicity, rules, procedures, demographics and other policies mutually established by the Exchange and Contractor, which may be amended by mutual agreement from time to time. Standard reports shall include, but are not limited to:

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

(b) Nurse advice line volume, talk time, and topics discussed;

(c) Use of Plan website;

(d) Quality assurance activities;

(e) Enrollment reports; and

(f) Premiums collected.

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

9. Contractor Staff Training about the Exchange

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

(b) Contractor shall provide the Exchange with a monthly calendar of staff trainings. Contractor shall make available training slots for the Exchange staff upon request.

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

Attachment 7. Quality, Network Management and Delivery System Standards

Quality, Network Management and Delivery System Standards

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

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

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

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

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

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

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

(i) Enrollees and other consumers;

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

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

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

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

(a) Leapfrog

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

(c) California Joint Replacement Registry developed by the CHCF, California Orthopedic Society and Pacific Business Group on Health (PBGH)

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

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

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

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

(h) IHA Payment Bundling demonstration

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

(j) CMMI Comprehensive Primary Care initiative (CPC)

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

(l) Contractor-sponsored accountable care programs

(m) California Perinatal Quality Care Collaborative

(n) California Quality Collaborative

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

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

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

(a) Contractor providing, as part of its annual completion of the eValue8 Submission (see Section 3.05) Racial, Cultural and Language Competency module (Section 2.5.1.7 in the 2013 QHP Solicitation), which describes its programs to address health equity and health disparities;

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

(c) Describing to the Exchange how, if at all, it collects and uses the data elements described in 3.04(d) that follows regarding Exchange's Enrollees to: (1) understand how health care is being differently delivered to different populations and (2) to support targeted clinical or preventive services; and

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

(i) Race

(ii) Ethnicity

(iii) Gender

(iv) Primary language

(v) Disability status

(vi) Sexual orientation

(vii) Gender identity

Article 2. Accreditation: NCQA or URAC

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

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

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

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

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

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

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

3.01 HEDIS and CAHPS Reporting. Contractor shall submit to the Exchange HEDIS and CAHPS scores to include the measure numerator, denominator and rate for the required measures set that is reported to NCQA Quality Compass and/or DHCS, per each Product Type for which it collects data in California. These measures may change as some may be added or removed by NCQA. The Exchange reserves the right to use the Contractor-reported measures scores to construct Contractor summary quality ratings that the Exchange may use for such purposes as supporting consumer choice and the Exchange's plan oversight management.

(a) Contractor shall report scores for Measurement Year ("MY") 2011, MY2012, MY2013 and MY2014 based on data reported to NCQA Quality Compass and/or DHCS County-level Product reporting for those periods. Contractor is not required to report DHCS County-level reporting HEDIS or CAHPS information if not already doing so for Medi-Cal if it is not already doing so for Medi-Cal.

(b) Contractor shall collect its HEDIS and CAHPS data consistent with the standard measures set that is reported to NCQA Quality Compass and any applicable DHCS County-level reporting for those periods. Contractor shall report scores separately for each Quality Compass Product Type and/or DHCS County-level product type (e.g.: commercial HMO/POS, commercial PPO, Medicaid HMO), for California. Beginning in MY2014, Contractor shall include Exchange Enrollees as part of its commercial population for the respective product types.

(c) For the purposes of determining Performance Measurement Standards (see Attachment 14), the Exchange shall use the most appropriate Product Type based on the plan design and network operated for the Exchange. If appropriate, the Exchange may blend Product Type scores (e.g., combining Commercial and Medi-Cal scores).

(d) Contractor may be required to conduct QHP product type CAHPS measurement and reporting effective MY 2014 and annually thereafter.

(e) Subject to changes in federal requirements, Contractor shall not be required to collect and report QHP-specific HEDIS measures.

(f) The timeline for Contractor's HEDIS and CAHPS quality data submission shall be consistent with the timeline for submitting data to the NCQA Quality Compass and/or DHCS.

(g) The Exchange reserves the right, as measures are added or removed from the national standard measures, to add or rename measures to the standard HEDIS measures and will provide Contractor sufficient prior notice of intent to add or rename measures to the existing measure set.

(h) Contractors electing to pursue URAC plan accreditation instead of NCQA accreditation per Article 2, are not exempt from these requirements.

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

(a) Deaths and readmissions;

(b) Serious complications related to specific conditions;

(c) Hospital acquired conditions; and

(d) Healthcare associated infections.

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

3.03 Data Submission Requirements to the Exchange. Contractor shall submit a complete data set, inclusive of all member and provider identified data, claims, encounter and pharmacy data, on a quarterly basis to the Exchange or the Exchange's designated recipient to be used by the Exchange as it determines to be necessary. Such submissions will conform to all applicable Federal and State personal health information and related privacy laws, rules and regulations, and shall comply with the terms and conditions set forth in the Agreement by and between Contractor and the Exchange. Contractor will bear the full cost of data collection, extraction and submission; provided, however, that except as expressly set forth in this Attachment or the Agreement, Contractor will not be required to pay for any expenses related to the analysis of that data in order to comply with the terms of this Agreement. Contractor is not required to provide the Exchange with Individually Identifiable Health Information as to any Enrollee unless authorized by law. When conformance with data submission requirements necessitates disclosure of Individually Identifiable Health Information not authorized by law, such information shall be submitted by Contractor to a third-party vendor selected by the Exchange and who enters into an agreement with the Contractor to do data analysis and provide reports and analyses to the Exchange. Such vendor must be a Business Associate of the Contractor who shall protect the information provided as required by applicable laws, rules and regulations. Any Personally Identifiable Health Information disclosed to the third party vendor shall be de-identified in any subsequent analysis provided to the Exchange. If the use of such a vendor is necessary, the details of the arrangement shall be set forth in a data use and reporting agreement mutually agreeable to the Exchange and the Contractor.

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The Exchange has provided the data file formats contained in Appendix 1 to this Attachment 7 as its initial expectation of Contractors' provision of data to support oversight requirements, including actuarial review, clinical quality improvement, network management and fraud and waste reduction, delivery system reform goals, consumer information and research. Additional data and expanded file formats may be requested in the future in support of the Exchange contributing data to statewide collaborative efforts to advance development of an all payer claims database.

Specific data submission areas in Appendix 1 include:

- Plan and Product
- Member
- Member History
- Contracted PMGs
- Providers (all providers with paid claims, including non-contracted)
- Hospitals (all providers with paid claims, including non-contracted)
- Professional Claims
- Hospital Claims Header
- Hospital Claims Detail
- Drug Claims
- Total Medical Expense (non-claims payment)

If Contractor does not maintain such information and/or is unable to produce such information in the file format requested by the Exchange, Contractor shall coordinate with the Exchange with a plan to address data gaps or format preferences prior to the Contractor's submission of such information by the fourth quarter of 2014. For any non-paid claims for capitated services, the Contractor shall provide full and complete encounter data.

3.04 eValue8 Submission. During each Contract Year, Contractor shall submit to the Exchange certain information that is a required disclosure under the eValue8 Health Plan Request for Information, as modified by the Exchange in the California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012, and may be updated from time to time by the Exchange:

(a) Plan Profile, including Racial, Cultural and Language Competency

(b) Consumer Engagement

(c) Provider Measurement and Rewards

(d) Pharmaceutical Management

(e) Prevention and Health Promotion

(f) Chronic Disease Management

(g) Behavioral Health

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

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

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

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

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

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

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

Article 4. Preventive Health and Wellness

4.01 Health and Wellness Services. Contractor is required to encourage and monitor the extent to which Plan Enrollees obtain preventive health and wellness services within the first year of enrollment. Contractor shall develop and provide a report annually regarding on how it is maximizing Plan Enrollees access to preventive health and wellness services. Report information should be coordinated with existing national measures, whenever possible, including HEDIS. As part of that report, Contractor shall assess and discuss the participation by Plan Enrollees in:

(a) necessary preventive services appropriate for each enrollee;

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

(c) obesity management, if applicable.

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

Contractor shall develop and provide reports on how it is participating in community health and wellness promotion. Report information should be coordinated with existing national measures, whenever possible.

4.03 Health and Wellness Enrollee Support Process. Upon Contractor Plan certification, Contractor shall submit to the Exchange the following information:

(a) Health and wellness communication process to Enrollee and Participating Provider, or other caregiver;

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

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

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

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

5.01 Encouraging Consumers' Access to Appropriate Care. Contractor is encouraged to assist Enrollees in selecting a Primary Care Provider, Federally Qualified Health Center or a Patient-Centered Medical Home (PCMH) within sixty (60) days of enrollment. In the event the Enrollee does not select a primary care provider (PCP) within the allotted timeframe, Contractor may auto-assign the enrollee to a PCP and the assignment shall be communicated to the Plan Enrollee. In the event of an auto-assignment, PCP assignment will be consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, and will consider geographic accessibility and existing family member assignment or prior provider assignment.

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

(a) Accountable Care Organizations (ACO);

(b) Patient Centered Medical Homes (PCMH);

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

(d) A focus on additional primary care recruitment, use of mid-level practitioners and development of new primary care and specialty clinics;

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

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

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

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

(i) Providing patient access to their health information;

(j) Promoting team care;

(k) The use of telemedicine; and

(l) Promoting the use of remote patient monitoring.

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

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

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

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

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

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

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

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

5.04 Identification and Services for At-Risk Enrollees. Contractor agrees to identify and proactively manage the Plan Enrollees with existing and newly diagnosed chronic conditions and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor will target the at risk enrollees, typically with one or more conditions, including, but not limited to, diabetes, asthma, heart disease or hypertension. As described in sections 3.06, Contactor shall determine the health status of its new enrollees that includes identification of chronic conditions and other significant health needs within the first one hundred twenty (120) days of enrollment, provided the Exchange has provided timely notification of enrollment. Contractor will provide the Exchange with a documented process, care management plan and strategy for targeting these specific Enrollees, which will include the following:

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

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

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

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

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

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

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

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

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

Article 6. Patient-Centered Information and Communication

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

6.02 Enrollee Cost Transparency. The Exchange and Contractor acknowledge and agree that information relating to the cost of procedures and services is important to enrollees, the Exchange, the Contractor and providers. The Exchange also understands that Contractor negotiates Agreements with providers, including physicians, hospitals, physician groups and other clinical providers, which may result in varied provider reimbursement levels for identical services and or procedures. In the event that Contractor's provider contracts result in different provider reimbursement levels that have an impact on Plan Enrollee costs within a specific region, as defined by paid claims for like CPT, ICD9/10 and DRG based services, Contractor agrees to provide the Exchange with its plan, measures and process to assist Plan Enrollees identify total cost and out-of-pocket cost information for the highest frequency and highest cost service(s) and or procedure(s). When available, this pricing information shall be prominently displayed and made available to both Plan Enrollees and contracted Contractor providers if provided. This information shall be updated on at least an annual basis unless there is a contractual change that would change enrollee out-of-pocket costs by more than 10%. In that case, information must be updated within 30 days of the effective date of the new contract.

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

6.04 Enrollee Shared Decision-Making. By 2015, Contractor shall demonstrate effective engagement of enrollees with information, decision support, and strategies to optimize self-care and make the best choices about their treatment, with materials from sources such as Consumer Reports, developed as part of the American Board of Internal Medicine ("ABIM") Foundation campaign, "Choosing Wisely" or structured shared decision-making programs.

By 2015, Contractor shall also provide specific information to the Exchange regarding the number of Plan Enrollees who have accessed consumer information and/or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including but not limited to breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life. Contractor shall report the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan. Contractor shall report annually to the Exchange documenting participation in these programs and their results, including clinical, patient experience and costs impacts and to the extent collected provide the results to the Exchange.

Article 7. Promoting Higher Value Care

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

7.02 Value Based Reimbursement Inventory and Performance. By the end of 2014, Contractor will provide an inventory of all current value based provider reimbursement methodologies within the geographic regions served by the Exchange. Value based reimbursement methodologies will include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and/or value measures. Integrated care models that receive such value based reimbursements may be included, but are not limited to, those referenced in Section 5.02.

This inventory must include:

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

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

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

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

For 2015, Contractor and the Exchange shall agree on the targeted percentage of providers to be reimbursed under value based provider reimbursement methodologies.

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

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

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

7.05 Payment Reform and Data Submission.

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

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

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

Article 8. Drug Formulary Changes

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

Quality, Network Management and Delivery System Standards
Glossary of Key Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1 to Attachment 7. Claims and Data File layouts

The Exchange has provided the following file layouts as an initial expectation of Contractors' provision of data to support oversight requirements (actuarial review, clinical quality improvement, network management, and fraud and waste reduction), delivery system reform goals, consumer information and research. All such reporting shall be subject to applicable Federal and State laws regarding the confidentiality and release of confidential personal and health information of enrollees. Additional data and expanded file formats may be requested in future periods in support of statewide collaborative efforts to advance development of an all payer claims database:

1. Plan & Product Information
2. Member
3. Member History
4. Contracted PMGs
5. Providers (all providers with paid claims, including non-contracted)
6. Hospitals (all providers with paid claims, including non-contracted)
7. Professional Claims
8. Hospital Claims Header
9. Hospital Claims Detail
10. Drug Claims
11. Total Medical Expense Reporting (non-claims payments)

Plan Layout					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
1	Plan_Name	Plan Name	Character	30	
2	Plan_CCCode	Covered California plan ID number for carrier (to be assigned)	Character	8	
3	Group_No	Plan-assigned Group number	Character	15	CC Exchange-specific number
4	Group_No_Suffix	Plan-assigned Group number with Suffix if applicable	Character	15	Optional
5	Product_Type	Health Plan Product: P=PPO, E=EPO, H= HMO or S= POS	Character	1	
6	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	
7	Metal	Metal level associated with benefit design	Character	10	
8	HealthAssessment	Name of Health Assessment tool or vendor (list Internal if internally developed)	Character	40	

Member File Layout					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
1	CC_MemberID	Unique code assigned by CC to the member	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a member	Character	20	
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
4	SSN	Member's SSN	Character	9	
5	Group_No	Plan-assigned Group number	Character	15	
6	Group_No_Suffix	Plan-assigned Group number with Suffix if applicable	Character	15	
7	M_Lname	Member's last name	Character	30	
8	M_Fname	Member's first name	Character	20	
9	M_MI	Member's middle initial	Character	5	
10	M_DOB	Member's date of birth	Date; mmddyyyy	8	
11	M_Gender	Member's Gender: M=male F=female U=unknown	Character	1	
12	M_Language	Member Primary Language	Character	10	Use ICEforHealth standard abbreviations
13	M_Race	Member Race	Character	10	
14	M_Ethnicity	Member Ethnicity	Character	10	
15	M_Addr1	Member's Street Address	Character	40	
16	M_Addr2	Member's Street Address2	Character	40	
17	M_City	Member's City	Character	40	
18	M_State	Member's State	Character	2	
19	M_Zip	Member zip code	Character	5	5 digit zip
20	M_ZipSuffix	Member zip code suffix	Character	4	4 digit zip suffix
21	M_Phone	Member phone	Character	15	
22	Eff_Date	Effective date of coverage	Date; mmddyyyy	8	Current effective date of coverage with benefit design
23	Term_Date	Termination date - Last day of continuous coverage	Date; mmddyyyy	8	
24	Eff_Date_Init	Original effective date of coverage	Date; mmddyyyy	8	Same as Eff_Date unless there is a break in coverage
25	Subsidy_Elig	Status of eligibility for subsidy (Y=Yes, N=No, P=Pending)	Character	1	Coding to be determined

Member File Layout					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
26	Subsidy_Type	Subsidy level (1=1xFPL, 2=2xFPL, 3=3xFPL, 4=4xFPL)	Character	6	Coding to be determined
27	Product_Type	Health Plan Product: P=PPO, S=HSA, E=EPO, H= HMO or O= POS	Character	1	
28	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	To be confirmed
29	PCP_ID	NPI of Primary Care Physician	Character	16	
30	Plan_PID	Plan ID for Primary Care Physician if NPI not available	Character	16	
31	Update	Add/Change/Delete (if change in member status)	Character	1	Optional

Member History File Layout					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
1	CC_MemberID	Unique code assigned by CC to the member	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a member	Character	20	
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
4	SSN	Member's SSN	Character	9	
5	M_Lname	Member's last name	Character	30	
6	M_Fname	Member's first name	Character	20	
7	M_MI	Member's middle initial	Character	5	
8	M_DOB	Member's date of birth	Date; mmddyyyy	8	
9	M_Gender	Member's Gender: M=male F=female U=unknown	Character	1	
10	Eff_Date	Effective date of coverage	Date; mmddyyyy	8	Current effective date of coverage with benefit design
11	Term_Date	Termination date - Last day of continuous coverage	Date; mmddyyyy	8	
12	Subsidy_Elig	Status of eligibility for subsidy	Character	1	
13	Subsidy_Type	Subsidy level (coding TBD)	Character	6	Coding to be determined
14	Product_Type	Health Plan Product: P=PPO, E=EPO, H= HMO or S= POS	Character	1	
15	Benefit_Design	Coding TBD pending selection of plan designs/alt plans	Character	2	To be confirmed
16	PCP_ID	NPI of Primary Care Physician	Character	16	
17	Plan_PID	Plan ID for Primary Care Physician if NPI not available	Character	16	

Physician Medical Group File					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	Notes
1	PMGID	Plan ID for Physician Medical Group	Character	12	
2	PMG	Provider Group Name	Character	30	
3	PMG_TaxID	Tax ID for Physician Medical Group	Character	12	
4	DMHC ID	DMHC ID for Physician Medical Group	Character	20	
5	CC_Regions	Covered California Regions serviced by Physician Medical Group	Character	60	Separate region numbers with a semicolon (e.g., 1;4;15;16)
6	PMG_HMO	PMG HMO Contract Flag (Y/N)	Character	1	
7	PMG_PPO	PMG PPO/EPO Contract Flag (Y/N)	Character	1	
8	PMG_HPN	PMG Narrow Network Flag (Y/N)	Character	1	
9	PMG_ACO	PMG ACO Contract Flag (Y/N)	Character	1	
10	PMG_MCal	PMG Medi-Cal Managed Care Contracting Flag (Y/N)	Character	1	
11	PMG_Cap	Contract with PMG for HMO services is primarily fully Capitated (C), Partially capitated (P), Fee-for-Service (F), Other (O)	Character	1	
12	PMG_HCap	Contract with PMG's referred hospital services is primarily fully Capitated (C), Shared Risk (S), Fee-for-Service (F), Other (O)	Character	1	

Provider File					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	Notes
1	P_Fname	Physician First Name	Character	20	
2	P_MI	Physician Middle Name or Initial	Character	5	
3	P_Lname	Physician Last Name	Character	30	
4	P_Suffix	Physician Type Suffix (e.g., MD, DO, etc.)	Character	20	
5	P_DOB	Physician Date of Birth (MM/DD/YYYY)	Date; mmddyyyy	8	
6	P_TaxID	Physician Tax ID Number	Character	12	
7	P_SSN	Physician SSN	Character	12	
8	NPI	Physician type-1 National Provider Identifier (NPI)	Character	12	
9	NPI2	Physician NPI Number (type-2 organizational)	Character	12	
10	DEA	Physician DEA Number	Character	12	Optional if Rx file contains provider NPI
11	Plan_PID	Physician ID Number Assigned by Plan	Character	20	Must match Field #29 from Member file layout
12	LicenseNo	Physician State Medical License Number (DO or NP license if acting as PCPs)	Character	20	Define if leading 0's added
13	P_Addr1	Physician Address Line 1	Character	30	
14	P_Addr2	Physician Address Line 2	Character	30	
15	P_City	Physician City	Character	30	
16	P_State	Physician State	Character	2	
17	P_Zip	Physician Zip Code	Character	10	
18	P_Phone	Physician Phone Number	Character	20	
19	Spec1	Physician Specialty 1 (primary)	Character	30	Provide summary table if abbreviations are used
20	Spec2	Physician Specialty 2 (secondary)	Character	30	
21	Spec3	Physician Specialty 3 (tertiary)	Character	30	
22	PMGID	Provider Group (Primary affiliation)	Character	12	Plan Number or code for contracted PMGs
23	PMGID2	Provider Group2 (Secondary affiliation)	Character	12	Plan Number or code for contracted PMGs
24	PMGID3	Provider Group3 (Tertiary affiliation)	Character	12	Plan Number or code for contracted PMGs
25	P_HMO	Physician HMO Contract Flag (Y/N)	Character	1	
26	P_PPO	Physician PPO/EPO Contract Flag (Y/N)	Character	1	
27	P_HPN	Physician Narrow Network Flag (Y/N)	Character	1	
28	P_ACO	Physician ACO Contract Flag (Y/N)	Character	1	
29	P_MCal	Physician Medi-Cal Managed Care Contracting Flag (Y/N)	Character	1	

Hospital File					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	Notes
1	H_TaxID	Facility Tax ID Number	Character	30	
2	H_ID	Facility ID Number Assigned by Health Plan	Character	20	
3	H_StateID	Facility ID Number Assigned by State Licensing Agency	Character	20	
4	H_Addr1	Facility Address Line 1	Character	30	
5	H_Addr2	Facility Address Line 2	Character	30	
6	H_City	Facility City	Character	30	
7	H_State	Facility State	Character	2	
8	H_Zip	Facility Zip Code	Character	10	
9	H_Phone	Facility Phone Number	Character	20	
10	H_HMO	Facility HMO Contract Flag (Y/N)	Character	1	
11	H_PPO	Facility PPO/EPO Contract Flag (Y/N)	Character	1	
12	H_HPN	Facility Narrow Network Flag (Y/N)	Character	1	
13	H_ACO	Facility ACO Contract Flag (Y/N)	Character	1	
14	H_MCal	Facility Medi-Cal Managed Care Contracting Flag (Y/N)	Character	1	
15	H_Cap	Service is/is not capitated (Y/N)	Character	1	

Professional Claims					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
1	P_Claim_ID	Plan internal claim number.	Character	20	
2	Plan_Member ID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	Needs to match # in member file layout
3	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
4	Line_No	The detail line number for the service on the claim.	Character	3	
5	DatePaid	Date the claim was paid.	Date; mmddyyyy	8	
6	SvcCount	A count of the number of services rendered by the provider.	Character	2	
7	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.	Character	4	
8	Init_Date	Date of the first service reported on the claim.	Date; mmddyyyy	8	
9	Last_Date	Date of the last service reported on the claim.	Date; mmddyyyy	8	
10	Dx1*	Primary diagnosis code from the claim line	Character	10	The diagnosis codes use the ICD-9-CM coding system but will transition to ICD-10. Confirm format re decimal placement
11	Dx2	Secondary diagnosis code from the claim line	Character	10	
12	Dx3	Third diagnosis code from the claim line	Character	10	
13	Dx4	Fourth diagnosis code from the claim line	Character	10	
14	Proc1	Procedure Code for line on a CMS-1500 claim form.	Character	5	
15	Mod1	The 2-character code of the first procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
16	Mod2	The 2-character code of the second procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
17	Mod3	The 2-character code of the third procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	

Professional Claims					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
18	Mod4	The 2-character code of the fourth procedure code modifier on the professional claim. Procedure modifiers only apply to CPT procedure codes.	Character	2	
19	RenderingPhysNPI	NPI for the provider who rendered or supervised the care.	Character	16	
20	RenderingPhysPlanID	The plan ID for the provider who rendered or supervised the care.	Character	20	not needed if Rendering Physician NPI provided
21	RenderingPhysID	The ID for the provider who rendered or supervised the care based on original claims submission (eg license #)	Character	16	
22	BillingOrgNPI	National Provider Identifier Type 1 for the provider who rendered or supervised the care.	Character	16	
23	BillingProviderID	The plan ID for the billing provider or group	Character	20	not needed if Billing Provider NPI provided
24	BillingProvider	The ID for the provider who rendered or supervised the care based on original claims submission (eg TaxID #)	Character	16	
25	P_BilledAmt	Amount billed for procedure	Numeric or dollar amt (####.##)	12	
26	P_Allowed	Amount allowed for procedure	Numeric or dollar amt (####.##)	12	
27	P_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt (####.##)	12	
28	P_MemberOOP	Amount paid by member	Numeric or dollar amt (####.##)	12	
29	P_Cap	Service is/is not capitated (Y/N)	Character	1	

*Carrier may submit up to 10 diagnoses codes

Facility Claim Header					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	**Notes**
1	H_Claim_ID	Plan internal claim number.	Character	20	
2	H_TaxID	Facility Tax ID Number	Character	30	
3	H_ID	Facility ID Number Assigned by Health Plan	Character	20	
4	Plan_Member ID	Unique code assigned by health plan to identify a member	Character	20	Needs to match # in member file layout
5	Dep_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
6	DatePaid	Date the claim was paid.	Date; mmddyyyy	8	
7	Bill_Type	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	Character	3	
8	Place	Code indicating the place of service (e.g., Acute Care Hospital, Office, Patient's Home, etc.). CMS standard values preferred.	Character	2	
9	Init_Date	Date of the first service reported on the claim.	Date; mmddyyyy	8	
10	Last_Date	Date of the last service reported on the claim.	Date; mmddyyyy	8	
11	Adm_Date	Date the patient was admitted to the facility	Date; mmddyyyy	8	
12	Dc_Date	Date the patient was discharged from the facility	Date; mmddyyyy	8	
13	Dc_Disp	The UB-04 standard patient status code, indicating patient disposition at the time of billing.	Character	3	
14	Dx1*	Primary diagnosis code from the claim line	Character	10	The diagnosis codes use the ICD-9-CM coding system but will transition to ICD-10. Confirm format re decimal placement
15	Dx2	Secondary diagnosis code from the claim line	Character	10	
16	Dx3	Third diagnosis code from the claim line	Character	10	
17	Dx4	Fourth diagnosis code from the claim line	Character	10	
18	Dx5	Fifth diagnosis code from the claim line	Character	10	
19	Dx6	Sixth diagnosis code from the claim line	Character	10	

Facility Claim Header					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	**Notes**
20	H_Proc1	The primary ICD-9 procedure code on the facility claim.	Character	7	
21	H_Proc2	The secondary ICD-9 procedure code on the facility claim.	Character	7	
22	H_Proc3	The third ICD-9 procedure code on the facility claim.	Character	7	
23	H_Proc4	The fourth ICD-9 procedure code on the facility claim.	Character	7	
24	H_Proc5	The fifth ICD-9 procedure code on the facility claim.	Character	7	
25	H_Proc6	The sixth ICD-9 procedure code on the facility claim.	Character	7	
26	AdmittingProviderID	NPI for the admitting provider	Character	20	
27	AttendingProviderID	NPI for the rendering provider	Character	20	
28	AdmittingProviderID	PlanID for the admitting provider	Character	10	Optional if NPI is reported
29	AttendingProviderID	PlanID for rendering provider	Character	10	Optional if NPI is reported
30	POA1	CMS Code indicating whether primary Dx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
31	POA2	CMS Code indicating whether secondary Dx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
32	POA3	CMS Code indicating whether tertiary Dx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
33	POA4	CMS Code indicating whether quaternary Dx was present on admission	Character	1	(W,N,Y,U, 1 etc.)
34	H_BilledAmt	Amount billed for admission	Numeric or dollar amt (####.##)	12	
35	H_Allowed	Amount allowed for admission	Numeric or dollar amt (####.##)	12	
36	H_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt (####.##)	12	
37	H_MemberOOP	Amount owed/paid by member	Numeric or dollar amt (####.##)	12	

*Carrier may submit up to 10 diagnoses codes

Facility Claim Detail					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	**Notes**
1	H_Claim ID	The carrier's internal claim number.	Character	20	Needs to match #1 in hospital claim header
2	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	Needs to match # in member file layout
3	Dependent_Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	Needs to match # in member file layout
4	Line Number	The detail line number for the service on the claim.	Character	3	
5	Service Count	A count of the number of services/units rendered by the provider.	Character	3	
6	Service_Date	The date of service for this detail record.	Date; mmddyyyy	8	
7	H_Proc1	The primary ICD-9 procedure code on the facility claim.	Character	7	
8	H_Proc2	The secondary ICD-9 procedure code on the facility claim.	Character	7	
9	H_Proc3	The third ICD-9 procedure code on the facility claim.	Character	7	
10	H_Proc4	The fourth ICD-9 procedure code on the facility claim.	Character	7	
11	H_Proc5	The fifth ICD-9 procedure code on the facility claim.	Character	7	
12	H_Proc6	The sixth ICD-9 procedure code on the facility claim.	Character	7	
13	Rev_Code	The CMS standard revenue code from the facility claim.	Character	3	
14	D_BilledAmt	Amount billed for procedure	Numeric or dollar amt (####.##)	12	
15	D_Allowed	Amount allowed for procedure	Numeric or dollar amt (####.##)	12	
16	D_Deductible	Applied to deductible (Y/N)	Numeric or dollar amt (####.##)	12	
17	D_MemberOOP	Amount paid by member	Numeric or dollar amt (####.##)	12	

Drug Claims Layout					
Field #	**Field Name**	**Description**	**Field Type/ Format**	**Length**	**Notes**
1	Claim ID	The carrier's internal claim number (ICN).	Character	20	
2	Plan_MemberID	Unique code assigned by health plan to identify a particular patient within their system.	Character	20	
3	Dependent _Suffix	Unique code assigned by the health plan to identify dependents (spouse, children, etc.)	Character	5	
4	NDC Number Code	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Character	11	
5	Days Supply	The number of days of drug therapy covered by this prescription.	Character	2	
6	Metric Quantity Dispensed	The number of units dispensed for the prescription drug claim, as defined by the NCPDP (National Council for Prescription Drug Programs) standard format.	Character	10	
7	Date of Service	The date of service for the drug claim.	Date; mmddyyyy	8	
8	Date Paid	The date the claim was paid.	Date; mmddyyyy	8	
9	Ordering Provider ID	Prescribing provider’s ID as supplied by plan (likely DEA)	Character	20	Optional if NPI is provided
10	Provider ID	Provider (Pharmacy) that submitted the claim as supplied by plan (TIN or other)	Character	12	Optional if NPI is provided
11	Prescriber NPI	Prescribing provider's National Provider Identifier Type 1	Character	10	
12	Attending Physician NPI	Attending Provider Submitted National Provider Identifier Type 1	Character	10	may be same as #10

Total Medical Expense Reporting (non-claims payments)					
Field #	**Field Name**	**Description**	**Field Type/Format**	**Length**	**Notes**
1	H_TaxID	Facility Tax ID Number	Character	30	Leave blank if payment not applicable
2	H_ID	Facility ID Number Assigned by Health Plan	Character	20	Leave blank if payment not applicable
3	PMGID	Plan ID for Physician Medical Group	Character	12	Leave blank if payment not applicable
4	PMG	Provider Group Name	Character	30	Leave blank if payment not applicable
5	PMG_TaxID	Tax ID for Physician Medical Group	Character	12	Leave blank if payment not applicable
6	DMHC ID	DMHC ID for Physician Medical Group	Character	20	Leave blank if payment not applicable
7	PaymentType	Type of payment C=Capitation P=Case Management or PMPM fee E=Episode-based payment I=Incentive Program R=Risk Settlement S=Salary-based incentive O=Other	Character	1	Include multiple entries as needed
8	BegDate	Beginning Date of Measurement/Reward period	Date; MMDDYYYY	8	
9	EndDate	Beginning Date of Measurement/Reward period	Date; MMDDYYYY	8	
10	PaymentAmt	Dollar value of payment	Numeric (no decimals)	10	
11	CC_Applied	Indicate of dollars are solely applicable to Exchange membership (Y/N)	Character	1	
11	ExchangeMM	Total MM for Exchange Enrollment for the period of the payment.	Numeric	12	Used to apportion payment dollars if dollars reported are not specific to Exchange membership
12	TotalMM	Total MM for Book of Business for which payment is applicable for the period reported above.	Numeric	16	

Appendix 2 to Attachment 7: Required Reports

Contractor shall provide such reports, data, documentation and other information reasonably requested by the Exchange and as reasonably necessary to document and evaluate Contractor's provision of Services in accordance with the terms and conditions set forth in the Agreement and under applicable laws, rules and regulations, including without limitation, the following items:

- Collaborative marketing and enrollment efforts, including, Contractor's marketing plan and documentation relating to testing of interfaces with Exchange's eligibility and enrolment system (Section 1.05(b);
- Evaluation of Contractor's performance (Section 1.10);
- Compliance with requirements for status as a Certified QHP (Section 3.01);
- Licensure and good standing (Section 3.02);
- Benefit plan design (Section 3.03);
- Sales and marketing practices for products through the Exchange and outside the Exchange (Section 3.04);
- Network adequacy standards (Section 3.05;
- Service Area (Section 3.05(a));
- Participating Provider Directory (Section 3.05(b));
- Participating Provider recruitment and retention (Section 3.05(c));
- Changes in Participating Provider network (Section 3.05(d),(e));
- Geographic distribution and changes in ECP network (Section 3.06);
- Applications and notices (Section 3.07);
- Rate information provided to Health Insurance Regulators and in such form as required by Exchange (Section 3.08, 3.09)
- Transparency in coverage (Section 3.10);
- Accreditation (Section 3.11);
- Segregation of funds (Section 3.12);
- Compliance with special rules governing American Indians or Alaskan Natives (Section 3.13);
- Participating Provider Agreements (Section 3.14);
- Out-of-network, other benefit costs and network requirements (Section 3.15);
- Credentialing (Section 3.16)
- Utilization review and appeals (Section 3.17);
- Customer service standards (Section 3.18) (see further listing below);
- Compliance programs (Section 3.19);
- Enrollment and eligibility reconciliations (Section 3.20 to 3.22);
- Minimum Participation Rates (section 3.23);
- Premium information and reconciliation (Section 3.24);
- Collection practices (Section 3.26);
- Appeals and grievances (Section 3.27);
- Enrollee and marketing materials (Section 3.28);
- Agent compensation, appointment and conduct (Section 3.29 and 3.30);
- Notice of changes (Section 3.31);
- Other financial information, including, audited financial statements, annual profit and loss statement and other financial information (Section 3.32);
- Nondiscrimination (Section 3.33);

- Conflict of interest (Section 3.34);
- Compliance with other laws (Section 3.35);
- Transition plan (Section 3.36);
- Contractor's representations and warranties (Section 3.37);
- Quality, Network Management and Delivery System Standards (Article 4). See further discussion below.
- Rate updates, premium collection and remittance (Section 5.01, 5.02)
- Participation fee, including, allocation of fee across entire risk pool (5.03(a)), payment information (Section 5.03(b) and information necessary to conduct evaluations (Section 5.03(c));
- Performance measures (Article 6);
- Recertification process (Section 7.02);
- Breach of agreement (Section 7.04);
- Insolvency (Section 7.06);
- Duties upon non-recertification (Section 7.07);
- Further assurance regarding transition and continuity of care (Section 7.08, 7.09);
- Insurance (Article 8);
- Privacy and security standards (Article 9);
- Books records and data, including, clinical records (Section 10.01), financial records (including electronic commerce standards) (Section 10.02); storage and back up (Sections 10.03 and 10.04), examination and audit (Section 10.05 and 10.06), and tax reporting (Section 10.08);
- Intellectual Property (Article 11);
- Quality, Network Management and Delivery System Standards (Attachment 7) (all following references are to sections in Quality, Network Management and Delivery System Standards unless otherwise indicated):
- Accreditation (Section 3.11 of the Agreement; Attachment 7, Article 2 of the Quality, Network Management and Delivery System Standards)
- HEDIS and CAPHS reporting (Attachment 7, Section 3.01)
- Participation in quality initiatives (Attachment 7, Section 1.02)
- Data sets (Attachment 7, Section 3.03)
- Enrollee reports (e.g., claims, utilization) (Attachment 7, Section 3.03)
- Hospital Compare program requirements (e.g., readmissions, hospital acquired conditions (Attachment 7, Section 3.02)
- eValue8 information (Attachment 7, Section 3.04)
- Health and wellness services (Attachment 7, Section 4.01)
- Prevention, Health and Wellness (Attachment 7, Article 4)
- Access, Coordination, and At-Risk Enrollee Support (Article 5)
- Patient Centered Care and Shared decision making (Article 6)
- Reward based Consumer incentive progress (Attachment 7, Section 7.01)
- Value-based reimbursement and performance (Attachment 7, Sections 7.02 through 7.04)
- Payment reform (Attachment 7, Section 7.05)
- Customer Service Standards, (Attachment 6), including:
    - Customer call volumes
    - Telephone responsiveness
    - Responsiveness to written correspondence
    - Number, accuracy, and timeliness of ID card distribution
    - Nurse advice line volume, talk time, and topics discussed
    - Use of Contractor's website

Reporting, Notification and Participation Requirements Specific to Attachment 7- Quality, Network Management and Delivery System Reform

Reporting and Data Submission	Notification	Participation
		1.01
1.02		1.02
	2.02	
	2.03	
2.04	2.04	
2.05		
3.01		
3.02 (by 2015)		
3.03		
3.04c,d		3.04b
3.05		
3.07		
4.01		
4.02		
4.03		
5.02		
5.04		
6.01		
6.02		
6.04 (by 2015)		
7.01 (when undertaken)		
7.02		
7.04		

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

Attachment 8. Monthly Rates - Individual Exchange [to be attached specifically for each Issuer]

Attachment 9. Rate Updates - Individual Exchange [to be attached specifically for each Issuer]

Attachment 10. Monthly Rates- SHOP [to be attached specifically for each SHOP Issuer]

Attachment 11. Rate Updates - SHOP [to be attached specifically for each Issuer]

Attachment 12. Participation Fee Methodology - Individual Exchange

Attachment 13. Participation Fee Methodology - SHOP

Attachment 14. Performance Measurement Standards

[Note: The Performance Measurement Standards will be considered by the Covered California Board at its May 23, 2013 meeting]

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

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

The assessment of the penalties by the Exchange shall be determined in accordance with the computation methodology set forth in the appendix to this Attachment 14 and shall based on the following conditions: (i) the aggregate amount at risk with respect to Contractor's failure to comply with each of the Performance Measurement Standards shall not exceed ten percent (10%) of the total Participation Fee that is payable to the Exchange in accordance with the terms set forth in Section 5.03 of the Agreement, (ii) the performance penalties shall be based on the weighted average assigned to each Performance Measurement Standard that the Contractor fails to meet or exceed, as such weighted averages are set forth in the table below ("Performance Measurement Table"), and (iii) the amount of performance penalty to be assessed with respect to Contractor's failure to meet a Performance Measurement Standard shall be offset (i.e., reduced) by a "credit" that is provided in the event that Contractor exceeds a Performance Measurement Standard in a separate category; provided, however, that in no event shall the credit to Contractor exceed the amount of aggregate amount of the performance penalty that may be assessed during any applicable period.

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

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

1. Call Center Operations

(a) Baseline Period: During the first six (6) months Contractor begins to take operational calls under this Agreement ("Baseline Period"), the parties will collaborate to evaluate and refine Performance Measurement Standards based upon the call volumes and arrival patterns established during the Baseline Period. Contractor shall take reasonable efforts to staff sufficiently during the Baseline Period to meet or exceed the Performance Measurement Standards listed below.

(b) 800 Number: Contractor shall make information available regarding the Exchange pursuant to Contractor's toll-free hotline (i.e., 1-800 number) that shall be available to enrollees of

Contractor both inside and outside the Exchange. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth at Section 3.18 to provide support Exchange Enrollees and in a manner designed to assure compliance with these Performance Measurement Standards.

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

- Switch reporting: monthly, quarterly and annually.
- Phone statistics, Performance Measurement Standards reporting and operations reporting: monthly, quarterly and annually.
- Accumulative monitoring scoring: weekly and monthly.

2. Performance Measurement Standards Reporting- Group 1 - Customer Service and Group 2 - Operations

(a) **Monthly Performance Report:** Beginning the first full calendar month after the expiration of the Baseline Period, Contractor shall monitor and track its performance each month against the Performance Measurement Standards set forth below. Contractor shall provide detailed supporting information (as mutually agreed by the parties) for each Monthly Performance Report to the Exchange in electronic format.

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

(c) **Performance Measurement Standards:**

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

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

(iii) Performance Guarantee Exceptions; Contractor shall not be responsible for any failure to meet a Performance Guarantee if and to the extent that the failure is excused pursuant to Section 12.07 of the Agreement (Force Majeure) or the parties agree that the lack of compliance is due to

the Exchange's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies the Exchange of the problem and uses commercially reasonable efforts to perform and meet the Performance Measurement Standards notwithstanding the Exchange's failure to perform or delay in performing.

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

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

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

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

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

(vii) Performance Guarantee Tables - The Performance Measurement Standards are set forth in the below table, Covered California Performance Standards.

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

(a) All performance measures in Group 3 are for measurement only in 2014 with no penalty or credit assessed in 2015. For measurement in years 2015 and thereafter,

penalty or credit will be assessed in 2016 and thereafter. For performance measures in Group 1 – Customer Service and Group 2 – Operations, measurement in year 2014 of penalty or assessment s will count for 50% each of the total performance assessment.

(b) Specific reporting requirements for HEDIS and CAHPS measures referenced in Attachment 14, Group 3 measures 3.1-3.4 are noted in Attachment 7, section 3.01

(c) Attachment 14, Group 3 measures 3.1- 3.4 related to HEDIS/CAHPS Quality Reporting System Measures for "Getting the Right Care" (3.1), "Access to Care" (3.2), "Staying Healthy/Prevention" (3.3) and "Plan Service" (3.4) are all derived from HEDIS and/or CAHPS measures as noted in Appendix 1 to this attachment 14.

(d) All HEDIS/CAHPS performance benchmark comparisons will be made to National HMO benchmarks regardless of the product and network type offered by QHPs.

(e) Given the diversity of products offered by QHPs and the diversity of the networks offered as part of those products, using existing commercial or Medi-Cal product type reporting for HEDIS performance may not be reasonable once adequate enrollment levels are reached for each QHP. Further, Federal regulations during the certification period may require Covered California- specific HEDIS reporting (by product line). Covered California will work with its QHPs and Plan Management Advisory Committee to determine the appropriate measurement methodology after 2014 to best represent the performance of each QHP specific to Covered California enrollees.

Covered California Performance Standards for Contractor

Group 1: Customer Service Performance Standards = 50% of Total Performance Penalty or Credit for Measurement Year 2014 (paid in 2015) 25% of Performance Penalty or Credit Thereafter		
Customer Service Measures		**Covered California Performance Requirements**
1.1	**Call Answer Timeliness for Covered California**	Expectation: 80% of calls answered 30 seconds. 5% of total performance penalty at risk. Performance Level: <80%- 5% performance penalty. 80%-90%: no penalty. >90%: 5% performance credit.
1.2	**Processing ID Cards**	Expectation: 99% sent within 10 business days of receiving complete and accurate enrollment information from the Exchange and premium. 5% of total performance requirement expected. Performance Level: <50%: 5% penalty of total performance requirement. 50-98%: 2.5% penalty of total performance requirement. 99%: no penalty.
1.3	**Telephone Abandonment Rate for Covered California**	Expectation: No more than 3% of incoming calls in a calendar month. 5% of total performance penalty at risk. Performance Level: >3% abandoned-: 5% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 5% performance credit.
1.4	**Initial Call Resolution for CC**	Expectation: 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue. 5% of total performance penalty at risk. Performance Level: <85%: 5% performance penalty. 85-95%: no penalty. >95%: 5% performance credit.
1.5	**Grievance Resolution**	Expectation: 95% of enrollee grievances resolved within 30 calendar days. 5% of total performance penalty at risk. Performance Level: <95% resolved within 30 calendar days: 5% performance penalty. 95% or greater resolved within 30 calendar days: no penalty. 95% or greater resolved within 15 calendar days: 5% performance credit

Group 2: Operational Performance Standards 50% of Performance Penalty or Credit for Measurement Year 2014 (paid 2015); 25% of Performance Penalty or Credit Thereafter		
Operational Standards		**Covered California Performance Requirements**
2.1	**Enrollment and payment transactions** **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: 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 bus days of receipt of the 834/820 file 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
2.2	**Effectuation of enrollment upon receipt of payment** **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: 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 3 bus days of receipt of the member's initial payment 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
2.3	**Member payment** **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The Exchange will receive the 820 file within 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. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
2.4	**Enrollment change upon non-receipt of member payment, 30 day notice and termination** **6 month pilot period: 10/1/13-3/31/14** **Measurement period: 4/1/14-12/31/14**	Expectation: The Exchange will receive the 834 file within one business day of receipt of change of the members' status 95% of the time and within 3 business days of receipt of change of the members' status 99% of the time within any given month. Expectation and Performance Level and methodology to be determined after the pilot period (based on pilot period).
2.5	**Member Email or Written Inquiries**	Expectation: Correspondence 90% response to email or written inquiries within 15 working days of inquiry. Does not include written grievances or appeals. 10% of total performance requirement expected. Performance Level: <70%: 10% penalty of total performance requirement. 70-90%: 5% penalty of total performance requirement. 90% or greater: no penalty. Greater than 90% in 2 days: 10% performance credit.
2.6	**Member Call Volume**	Track Only- No performance requirement or penalty assessment

	Group 2 continued: Operational Standards	**Group 2: Operational Performance Standards 25% of Performance Penalty or Credit**
2.7	**Data Submission specific to Attachment 7, Section 3.03**	Expectation: Full and regular submission of data according to the standards outlined. 10% of total performance requirement expected. Performance Level: Incomplete, irregular, late or non-useable data submission: 10% penalty of total performance requirement. Full and regular submission according to the formats specified and useable by Covered California within 30 days of each quarter end: no penalty.
2.8	**Reporting**	Expectation: Submission of all required reports to Covered California within contractually specified times (varies by report or type of report). 5% of total performance requirement expected. Performance Level: one or more reports submitted more than 4 months after required submission date: 5% penalty of total performance requirement. One or more reports submitted after 30 days of required submission date: 2.5% penalty of total performance requirement. All required reports submitted within 5 business days of required submission: no penalty.

Group 3: Covered California Performance Standards Quality, Network Management and Delivery System Standards 0.0% of Performance Penalty or Credit for Measurement Year 2014/ 50% of Performance Penalty or Credit Thereafter		
Quality, Network Management and Delivery Systems Standards		**Covered California Performance Requirements Covered California and Contractor shall work with the Covered California Advisory group to periodically review and adjust the specific measures within each of the measure sets [below] consistent with any applicable Federal regulations. In addition, Covered California will work with contractors as appropriate to adjust measure sets where a contractor does not have all of the specific HEDIS measures.**
3.1	**Quality Reporting System (QRS)- Getting the Right Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: Getting the Right Care- HEDIS/CAHPS Clinical Effectiveness measure set summary (Product type reporting)- 5% of total performance requirement expected. Performance Level: <50th PCT:5% penalty;51-75th PCT: no penalty; >75th PCT: 5% performance credit (vs. national HMO benchmark).
3.2	**Quality Reporting System (QRS)-Access to Care; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: Access to Care- HEDIS/CAHPS measure set summary (Product type reporting): 5% of total performance requirement expected. Performance Level: <50th PCT:5% penalty;51-75th PCT: no penalty; >75th PCT: 5% performance credit (vs. national HMO benchmark).
3.3	**Quality Reporting System (QRS) - Staying Healthy/Prevention; related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: Staying Healthy/Prevention- HEDIS/CAHPS measure set summary-(Product type reporting)- 5% of total performance requirement expected. Performance Level: <50th PCT: 5% penalty;51-75th PCT: no penalty; >75th PCT: 5% performance credit (vs. national HMO benchmark).
3.4	**Quality Reporting System (QRS-Plan Service); related to Attachment 7, Section 3.01. Specific measures noted in Appendix 1 to this Attachment 14.**	Expectation: Plan Service- CAHPS measure set summary (Product type reporting) 5% of total performance requirement expected. Performance Level: <50th PCT:5% penalty;51-75th PCT: no penalty; >75th PCT: 5% performance credit (vs. national HMO benchmark).

3.5	**eValue8 – specific to Attachment 7, Section 3.05**	Expectation: Total Covered California eValue8 performance, 795.5 points total. 10% of total performance penalty at risk. Performance Level: < 40% of total points: 10% performance penalty. 40-74% of total points-no penalty. 75% or greater of total points: 10% performance credit.
3.6	**Quality and Network Management- Health Status Assessment; Attachment 7, Section 3.06.**	Performance expectation to be determined in collaboration with QHPs based on 2014 measurement with preliminary target of exceeding QHP 50th percentile to avoid penalty NOTE: for 2014 measurement year/2015 penalty/credit assessment, track and report to QHPs only;5% penalty at risk thereafter (2015 measurement and beyond)
3.7	**Quality and Network Management- Preventive Health and Wellness; Attachment 7, Section 4.01.**	Performance expectation to be determined in collaboration with QHPs based on 2014 measurement with preliminary target of exceeding QHP 50th percentile to avoid penalty NOTE: for 2014 measurement year/2015 penalty/credit assessment, track and report to QHPs only;5% penalty at risk thereafter (2015 measurement and beyond)
3.8	**Quality and Network Management- New Care Models; Attachment 7, Section 5.02.**	Performance expectation to be determined in collaboration with QHPs based on 2014 measurement with preliminary target of exceeding QHP 50th percentile to avoid penalty NOTE: for 2014 measurement year/2015 penalty/credit assessment, track and report to QHPs only;5% penalty at risk thereafter (2015 measurement and beyond)
3.9	**Quality and Network Management- At Risk Enrollees; Attachment 7, Section 5.04**	Performance expectation to be determined in collaboration with QHPs based on 2014 measurement with preliminary target of exceeding QHP 50th percentile to avoid penalty NOTE: for 2014 measurement year/2015 penalty/credit assessment, track and report to QHPs only;5% penalty at risk thereafter (2015 measurement and beyond)

Group 4: Covered California Performance Standards for Covered California Potential 25% Credit		
Customer Service Measures		**Covered California Performance Requirements**
4.1	**Call Answer Timeliness for Covered California**	Expectation: 80% of calls answered 30 seconds. 6.25% of total performance penalty at risk. Performance Level: <80%- 6.25% performance penalty. 80%-90%: no penalty. >90%: 5% performance credit.
4.2	**Telephone Abandonment Rate for Covered California**	Expectation: No more than 3% of incoming calls in a calendar month. 6.25% of total performance penalty at risk. Performance Level: >3% abandoned-: 6.25% performance penalty. 2-3% abandoned: no penalty. <2% abandoned: 5% performance credit.
4.3	**Initial Call Resolution for Covered California**	Expectation: 85% of enrollee issues will be resolved within one (1) business day of receipt of the issue was received. 6.25% of total performance penalty at risk. Performance Level: <85%: 6.25% performance penalty. 85-95%: no penalty. >95%: 6.25% performance credit.
4.4	**Grievance Resolution for Covered California**	Expectation: 95% of enrollee grievances resolved within 30 calendar days. 6.25% of total performance penalty at risk. Performance Level: <95% resolved within 30 calendar days: 6.25% performance penalty. 95% or greater resolved within 30 calendar days: no penalty. 95% or greater resolved within 15 calendar days: 6.25% performance credit

Appendix - Computation of Performance Measurement Standards [to be attached]

Appendix 1 to Attachment 14. Quality, Network Management and Delivery Systems Standards Covered California Performance Requirements

3.1 Quality Reporting System (QRS) - Getting the Right Care- HEDIS/CAHPS Clinical Effectiveness measure set summary

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)

*certain CAHPS measures may not be available for all Product Types

3.2 - Quality Reporting System – (QRS) - Access to Care- HEDIS/CAHPS measure set summary

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 to 44 years and 45 to 64 years) HEDIS

*certain CAHPS measures may not be available for all Product Types

3.3 Quality Reporting System (QRS) - Staying Healthy/Prevention- HEDIS/CAHPS measure set summary

Adult Staying Healthy/Prevention
Checking for Cancer
Breast Cancer Screening
Cervical Cancer Screening
Colorectal Cancer Screening
Getting Help to Stay 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 & Physical Activity for Children & 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)

*certain CAHPS measures may not be available for all Product Types

3.4 Quality Reporting System (QRS) - Plan Service- CAHPS measure set summary

Plan Service
Claims Processing Composite (CAHPS)
Customer Service Composite (CAHPS)
Plan Information on Costs Composite(CAHPS)
Global Rating of Plan(CAHPS)

*certain CAHPS measures may not be available for all Product Types

Attachment 15 Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "Agreement") dated _____, 2013 between the California Health Benefit Exchange ("Covered Entity") and _____ ("Business Associate") is entered into in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. §1320d-d8, and its implementing regulations at 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Regulations") and attendant guidance; and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and its attendant regulations and guidance (the "HITECH Act"). HIPAA, the HIPAA Regulations and the HITECH Act are sometimes referred to collectively herein as "HIPAA Requirements."

I. Purpose of the Agreement.

Business Associate provides certain services on behalf of Covered Entity that require the Covered Entity to disclose certain identifiable health information to Business Associate. The parties desire to enter into this Agreement to permit Business Associate to have access to such information and comply with the business associate requirements of HIPAA, the HIPAA Regulations, and the HITECH Act, as each may be amended from time to time in accordance with the terms and conditions set forth in this Agreement.

II. Definitions.

Unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for such terms under 45 C.F.R. Parts 160 and 164 and the HITECH Act, each as amended from time-to-time.

III. Terms and Conditions.

Business Associate and Covered Entity (hereinafter, the "Parties") agree to the terms and conditions set forth herein.

A. Business Associate Obligations.

1. Applicable Law. The terms and conditions set forth in this Agreement shall become effective on the later of the Effective Date of this Agreement, April 14, 2003, or any new mandatory compliance date established for HIPAA, the HIPAA Regulations and/or the HITECH Act. The parties acknowledge and agree that HIPAA, the HIPAA Regulations and the HITECH Act may be amended and additional guidance and/or regulations may be issued after the date of the execution of this Agreement and may affect the Parties' obligations under this Agreement ("Future Directives"). The Parties agree to abide by such Future Directives as these Future Directives may affect the obligations of the Parties under the Covered California Qualified Health Plan contract (Exchange Agreement) and/or this Agreement. If Future Directives affect the obligations of the Parties, then Covered Entity shall notify Business Associate of Future Directives in writing within thirty (30) days before Future Directives are effective. The notification of Business Associate by Covered Entity of Future Directives that affect the obligations of the Parties related to the Business Associate relationship shall be considered amendments to this Agreement binding on both parties. Covered Entity's failure to notify Business Associate of Future Directives shall not relieve Business Associate of any obligations it may otherwise have under HIPAA Requirements.

2. Permitted Uses and Disclosures. Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, further use or disclose patient individually identifiable health information ("Protected Health Information" or "PHI") received from or created for the Covered Entity in any manner that would violate HIPAA, the HIPAA Regulations, the HITECH Act or Future Directives. Business Associate agrees to abide by the HIPAA Requirements with respect to the use or disclosure of Protected Health Information it creates, receives from, maintains, or electronically transmits for the Covered Entity. Business Associate further agrees that it will not use or disclose Protected Health Information beyond the purposes set forth in the Agreement or as required by law as defined in 45 C.F.R §164.103. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Exchange Agreement between the Parties, provided that such use or disclosure would not violate HIPAA, the HIPAA Regulations or the HITECH Act if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3. Compliance with Business Associate Agreement and HITECH Act. Effective February 17, 2010, Business Associate may use and disclose PHI that is created or received by Business Associate from or on behalf of Covered Entity if such use or disclosure, respectively, is authorized by this Agreement and complies with each applicable requirement of 45 C.F.R. § 164.504(e) and the HITECH Act. The additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference.

4. Use of Protected Health Information for Administrative Activities. Notwithstanding Section III.A.2 above, Business Associate may use or disclose Protected Health Information for management and administrative activities of Business Associate or to comply with the legal responsibilities of Business Associate; provided, however, the disclosure or use must be required by law or Business Associate must obtain reasonable assurances from the third party that receives the Protected Health Information that they will (i) treat the Protected Health Information confidentially and will only use or further disclose the Protected Health Information in a manner consistent with the purposes that the Protected Health Information was provided by Business Associate; and (ii) promptly report any breach of the confidentiality of the Protected Health Information to Business Associate. Provided further that, Business Associate will notify Covered Entity immediately upon receipt of a request for any disclosure of Protected Health Information required by law.

5. Accounting. Business Associate agrees to document disclosures of Protected Health Information and collect information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

(a) Business Associate agrees to provide to Covered Entity or an Individual upon Covered Entity's request, information collected in accordance with this Section, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 and, if required by and upon the effective date of, Section 13405(c) of the HITECH Act and related regulatory guidance.

6. Restriction. Effective February 17, 2010, and notwithstanding 45 C.F.R. § 164.522(a)(1)(ii), Business Associate must comply with an Individual's request under 45 C.F.R. § 164.522(a)(1)(i)(A) that Business Associate restrict the disclosure of Protected Health Information of the Individual if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

7. Fundraising. Any written fundraising communication occurring on or after February 17, 2010 that is a health care operation shall, in a clear and conspicuous manner and consistent with guidance to be provided by the Secretary, provide an opportunity for the recipient of the communications to elect not to receive any further such communication. An election not to receive any further such communication shall be treated as a revocation of authorization under Section 45 C.F.R. § 164.508. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

8. S**ale of Protected Health Information.** Upon the effective date of Section 13405(d) of the HITECH Act , Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Health Information that is created or received by Business Associate from or on behalf of Covered Entity unless: (1) pursuant to an authorization by the Individual in accordance with 45 C.F.R. § 164.508 that includes a specification for whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that Individual; or (2) as provided for and consistent with Section 13405(d)(2) of the HITECH Act and regulations to be issued by the Secretary, upon the effective date of such regulations. However, in no instance may Business Associate receive remuneration pursuant to this Section without prior written authorization by Covered Entity.

9. Marketing. A communication occurring on or after February 17, 2010 by Business Associate that is described in the definition of marketing in 45 C.F.R. § 164.501(1)(i), (ii) or (iii) for which Covered Entity receives or has received direct or indirect payment (excluding payment for treatment) in exchange for making such communication, shall not be considered a health care operation unless: (1) such communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or (2) the communication is made by Business Associate on behalf of the Covered Entity and the communication is otherwise consistent with this Agreement. However, no communication pursuant to this Section may be made by Business Associate without prior written authorization by Covered Entity.

10. Safeguarding the Privacy of Protected Health Information. Business Associate agrees that it shall utilize physical, administrative and technical safeguards to ensure that Protected Health Information is not used or disclosed in any manner inconsistent with this Agreement or the purposes for which Business Associate received Protected Health Information from or created Protected Health Information for the Covered Entity. Business Associate further agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Protected Health Information that Business Associate creates, receives, maintains or transmits electronically on behalf of Covered Entity under the Agreement. Upon request, Business Associate shall provide the Covered Entity with a written description of the physical, administrative and technical safeguards adopted by Business Associate to meet its obligations under this Section.

11. **Security Safeguards.** Business Associate acknowledges that, effective February 17, 2010, 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 will apply to Business Associate in the same manner that such sections apply to covered entities and are incorporated into this Agreement by reference. The additional requirements of the HITECH Act that relate to security and that apply to covered entities also will apply to Business Associate and are incorporated into this Agreement by reference. Business Associate agrees to implement the technical safeguards provided in guidance issued annually by the Secretary for carrying out the obligations under the Code of Federal Regulation sections cited in this Section and the security standards in Subpart C of Part 164 of Title 45 of the Code of Federal Regulations.

12. Employee Training. Business Associate shall train its workforce members who assist in the performance of functions and activities under this Agreement, and who access or disclose Protected Health Information, on information privacy and security requirements. Business Associate shall impose appropriate disciplinary measures on members who intentionally violate Business Associate's privacy and security requirements, including termination of employment if appropriate.

13. Sanctions. Business Associate understands that a failure to comply with HIPAA, the HITECH Act and the HIPAA Regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA Regulations.

14. Breach Notification. Business Associate agrees to implement response programs and record-keeping systems to enable Business Associate to comply with the requirements of this Section and 13402 of the HITECH Act and the regulations implementing such provisions, currently Subpart D of Part 164 of Title 45 of the Code of Federal Regulations, when Business Associate detects or becomes aware of unauthorized access to information systems or documents that contain Protected Health Information. Business Associate agrees to mitigate any effects of the inappropriate use or disclosure of Protected Health Information by Business Associate.

(a) Business Associate agrees to notify Covered Entity, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, systems, documents or electronic systems which contain unsecured Protected Health Information, including, without limitation, any Security Incident, instance of theft, fraud, deception, malfeasance, or use, access or disclosure of Protected Health Information which is inconsistent with the terms of this Agreement (an "Incident") immediately upon having reason to suspect that an Incident may have occurred, and typically prior to beginning the process of verifying that an Incident has occurred or determining the scope of any such Incident, and regardless of the potential risk of harm posed by the Incident. Notice shall be provided to the Covered Entity's representative designated in this Agreement. Upon discovery of a breach or suspected Incident, Business Associate shall take:

(i) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

(ii) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

(b) In the event of any such Incident, Business Associate shall further provide to Covered Entity, in writing, such details concerning the Incident as Covered Entity may request, and shall cooperate with Covered Entity, its regulators and law enforcement to assist in regaining possession of such unsecured Protected Health Information and prevent its further unauthorized use, and take any necessary remedial actions as may be required by Covered Entity to prevent other or further Incidents. Business Associate and Covered Entity will cooperate in developing the content of any public statements.

(c) If Covered Entity determines that it may need to notify any Individual(s) as a result of such Incident that is attributable to Business Associate's breach of its obligations under this Agreement, Business Associate shall bear all reasonable direct and indirect costs associated with such determination including, without limitation, the costs associated with providing notification to the affected Individuals, providing fraud monitoring or other services to affected Individuals and any forensic analysis required to determine the scope of the Incident.

(d) In addition, Business Associate agrees to update the notice provided to Covered Entity under Section 14(a) of this Agreement of such Incident to include, to the extent possible and as soon as possible working in cooperation with Covered Entity, the identification of each Individual whose unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Incident and any of the following information Covered Entity is required to include in its notice to the Individual pursuant to 45 C.F.R. § 164.404(c):

(i) A brief description of what happened, including the date of the Incident and the date of discovery of the Incident, if known;

(ii) A description of the types of unsecured Protected Health Information that were involved in the Incident (e.g., Social Security number, full name, date of birth, address, diagnosis);

(iii) Any steps the Individual should take to protect themselves from potential harm resulting from the Incident;

(iv) A brief description of what is being done to investigate the Incident, mitigate the harm and protect against future Incidents; and

(v) Contact procedures for Individuals to ask questions or learn additional information which shall include a toll-free number, an e-mail address, Web site, or postal address (provided, Subsection v is only applicable if Covered Entity specifically requests Business Associate to establish contact procedures).

(e) Such additional information must be submitted to Covered Entity immediately at the time the information becomes available to Business Associate.

(f) If the cause of a breach of Protected Health Information is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required notifications and reporting of the breach as specified in 42 U.S.C. § 17932 and its implementing regulations, including, without limitation, individual notifications, notification to media outlets and to the Secretary of the Department of Health & Human Services. If a breach of unsecured Protected Health Information involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. Such notification(s) and required reporting shall be done in cooperation with Exchange and subject to Exchange's review and approval. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to Covered Entity in addition to Business Associate, Business Associate shall notify Covered Entity, and Covered Entity and Business Associate may take appropriate action to prevent duplicate reporting.

15. Subcontractors and Agents of Business Associate. Business Associate agrees to enter into written contracts with any of its agents or independent contractors (collectively, "subcontractors") who receive Protected Health Information from Business Associate or create, maintain, or transmit electronically, Protected Health Information on behalf of the Covered Entity, as a subcontractor to Business Associate, and such contracts shall obligate Business Associate's subcontractors to abide by the same conditions and terms as are required of Business Associate under this Agreement. Upon request, Business Associate shall provide the Covered Entity with a copy of any written agreement or contract entered into by Business Associate and its subcontractors to meet the obligations of Business Associate under this Section.

(a) Business Associate shall, upon knowledge of a material breach by a subcontractor of the subcontractor's obligations under its contract with Business Associate, either notify such subcontractor of such breach and provide an opportunity for subcontractor to cure the breach; or, in the event subcontractor fails to cure such breach or cure is not possible, Business Associate shall immediately terminate the contract with subcontractor.

(b) To the extent that any of Business Associate's subcontractors will have access to any Protected Health Information that is received, created, maintained or transmitted electronically, Business Associate shall require such agents and subcontractors to agree to implement reasonable and appropriate safeguards to protect such electronic Protected Health Information.

16. Availability of Information to Covered Entity and Individuals. Business Associate agrees to provide access and information as follows:

(a) Business Associate shall provide access as may be required, and in the time and manner designated by Covered Entity (upon reasonable notice and during Business Associate's normal business hours) to Protected Health Information in a Designated Record Set, to Covered Entity (or, as directed by Covered Entity), to an Individual, in accordance with 45 C.F.R. § 164.524. Designated Record Set means the group of records maintained for Covered Entity that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for Covered Entity health plans; or those records used to make decisions about individuals on behalf of Covered Entity. Business Associate shall use the forms and processes developed by Covered Entity for this purpose and shall respond to requests for access to records transmitted by Covered Entity within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

(b) If Business Associate maintains an Electronic Health Record with Protected Health Information, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. § 17935(e).

(c) If Business Associate receives data from Covered Entity that was provided to Covered Entity by the Social Security Administration, upon request by Covered Entity, Business Associate shall provide Covered Entity with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

17. Access by Covered Entity and Secretary of U.S. Department of Health & Human Services. Business Associate agrees to allow Covered Entity and the Secretary of the U.S. Department of Health & Human Services ("Secretary") access to its books, records and internal practices with respect to the disclosure of Protected Health Information for the purposes of determining the Business Associate's compliance with the HIPAA Privacy Regulations. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Agreement, Business Associate shall notify Covered Entity and provide Covered Entity with a copy of any Protected Health Information that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such Protected Health Information to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. § 17934(c).

B. Termination of Agreement.

1. Termination Upon Material Breach. The Covered Entity may, in its sole discretion, terminate the Exchange Agreement, including this Agreement, upon determining that Business Associate violated a material term of this Agreement. If the Covered Entity makes such a determination, it shall inform Business Associate in writing that the Covered Entity is exercising its right to terminate this Agreement under this Section III.B and such termination shall take effect immediately upon Business Associate receiving such notification of termination. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA Regulations, if Business Associate knows of a material breach or violation by Covered Entity, it shall take all actions required under the HITECH Act and HIPAA Regulations.

2. Reasonable Steps to Cure Material Breach. At the Covered Entity's sole option, the Covered Entity may, upon written notice to Business Associate, allow Business Associate an opportunity to take prompt and reasonable steps to cure any violation of any material term of this Agreement to the complete satisfaction of the Covered Entity within ten (10) calendar days of the date of written notice to Business Associate. Business Associate shall submit written documentation acceptable to the Covered Entity of the steps taken by Business Associate to cure any material violation. If Business Associate fails to cure a material breach within the specified time period, then the Covered Entity shall be entitled to terminate this Agreement under Section III.B above, if feasible.

3. Amendment. Covered Entity may in its sole discretion terminate the Exchange Agreement, including this Agreement upon thirty (30) calendar days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to Section III.A.1 and Section III.F of this Agreement, or (ii) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of Protected Health Information that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and/or the HITECH Act.

4. Return of Protected Health Information to Covered Entity Upon Termination. Upon termination of the Agreement for any reason, Business Associate shall return all Protected Health Information to the Covered Entity. The Covered Entity may request in writing that Business Associate destroy all Protected Health Information upon termination of this Agreement rather that returning Protected Health Information to the Covered Entity. If the return or destruction of Protected Health Information is not feasible upon termination of the Agreement, then Business Associate shall explain in writing, directed to the Covered Entity's Chief Privacy Officer, why such return or destruction is not

feasible. If such return or destruction is not feasible, then Business Associate agrees that it shall extend its obligations under this Agreement to protect the Protected Health Information. The Business Associate shall limit its use or disclosure of such Protected Health Information to only those purposes that make it infeasible to return or destroy the Protected Health Information and shall maintain such Protected Health Information only for that period of time that return or destruction of Protected Health Information remains infeasible.

5. Conflicts. The terms and conditions of this Agreement will override and control over any conflicting term or condition of other agreements between the Parties. All non-conflicting terms and conditions of such agreements shall remain in full force and effect.

6. No Third-Party Beneficiary Rights. Nothing express or implied in this Agreement is intended or shall be interpreted to create or confer any rights, remedies, obligations or liabilities whatsoever in any third party.

7. Notice. Except as otherwise provided in Section I.A.14(a), any notice permitted or required by this Agreement will be considered made on the date personally delivered in writing or mailed by certified mail, postage prepaid, to the other party at the address set forth in the execution portion of this Agreement.

8. Amendment. The Parties agree to take such action as is necessary to implement the standards, requirements, and regulations of HIPAA, the HIPAA Regulations, the HITECH Act, and other applicable laws relating to the security or confidentiality of health information. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity concerning the terms of any amendment to the Agreement consistent with the standards, requirements and regulations of HIPAA, the HIPAA Regulations, the HITECH Act or other applicable laws.

9. Relationship of the Parties. The Parties hereto acknowledge that Business Associate shall be and have the status of independent contractor in the performance of its obligations under the terms of this Agreement as to Covered Entity. Nothing in this Agreement shall be deemed or construed to create a joint venture or partnership between Covered Entity and Business Associate, nor create an agency relationship between Covered Entity and Business Associate.

10. Indemnification by Business Associate. Business Associate shall protect, indemnify and hold harmless the Covered Entity, its officers and employees from all claims, suits, actions, attorney's fees, costs, expenses, damages, penalties, judgments or decrees arising out of the failure by Business Associate to comply with the requirements of this Agreement, the HIPAA Requirements and all Future Directives; provided however that such indemnification shall be conditioned upon the Covered Entity's giving prompt notice of any claims to Business Associate after discovery thereof and cooperating fully with Business Associate concerning the defense and settlement of claims.

C. Miscellaneous.

1. Exception to Limitations and Exclusions. Business Associate's obligations under this Agreement and any breach by Business Associate of the obligations in this Agreement shall not be subject to any limitations on damages suffered by Covered Entity that may be specified in any agreement, invoice, statement of work or similar document setting forth the services Business Associate is providing to Covered Entity ("Contract"). No limitation or exclusion in any Contract shall limit Covered Entity's rights to recover from Business Associate damages, losses or sanctions suffered by Covered Entity to the extent of amounts recovered by, or sanctions awarded to, a third party which are caused by Business Associate's breach of the obligations in this Agreement, regardless of how such amounts or sanctions awarded to such third party are characterized.

2. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations, the HITECH Act or other laws relating to security and privacy, which involve inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

3. Modification. This Agreement will be modified only by a written document signed by each party.

4. Waiver. The waiver by Business Associate or Covered Entity of a breach of this Agreement will not operate as a waiver of any subsequent breach. No delay in acting with regard to any breach of this Agreement will be construed to be a waiver of the breach.

5. Assignment. This Agreement will not be assigned by Business Associate without prior written consent of the Covered Entity. This Agreement will be for the benefit of, and binding upon, the parties hereto and their respective successors and permitted assigns.

6. Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA Regulations and applicable state or federal laws. The parties agree that any ambiguity in the terms and conditions of this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

7. Governing Law. The interpretation and enforcement of this Agreement will be governed by the laws of the State of California. Exclusive venue shall be in Sacramento County, California.

8. Headings. The section headings contained in this Agreement are for reference purposes only and will not affect the meaning of this Agreement.

9. Counterparts. This Agreement may be executed in counterparts, each of which will be deemed to be an original, but all of which together will constitute one and the same.

IN WITNESS WHEREOF, Covered Entity and Business Associate execute this Agreement to be effective on the last date written below, or, if no date is inserted, the Execution Date of the other Agreement referenced above (the "Effective Date").

COVERED HEALTH ENTITY: The California Health Benefit Exchange

By: _____

Printed Name: _____

Title: _____

Date: _____

Notice Address:

_____

_____

_____

Telephone: _____

Fax: _____

Email: _____

BUSINESS ASSOCIATE:_____

_____

By: _____

Printed Name: _____

Title: _____

Date: _____

Notice Address:

_____

_____

_____

Telephone: _____

Fax: _____

Email: _____