18 Quality

The Exchange's "Triple Aim" framework seeks to (1) improve the patient care experience including quality and satisfaction, (2) improve the health of the entire California population, and (3) reduce the per capita cost of covered services. The Exchange also seeks to reduce health care disparities and reduce administrative burden on health plans and providers. The Quality and Delivery System Reform standards outlined in the QHP Issuer Contract describe the ways the Exchange and contracted health plans will focus on the promotion of better care and higher value for plan enrollees and other California health care consumers. This section of the application assesses Applicant's current and future capacity to work with the Exchange to achieve these aims.

18.1 Accreditation

Questions required only for new entrant Applicants.

Applicant must be accredited by one of the following bodies: (1) Utilization Review Accreditation Commission (URAC); (2) National Committee on Quality Assurance (NCQA); (3) Accreditation Association for Ambulatory Health Care (AAAHC). The following questions will be used to assess Applicant's current accreditation status of its product(s) as well as any recognition or accreditation of other health programs and activities (e.g. case management, wellness promotion, etc.).

18.1.1 Applicant is responding for the following products for reporting accreditation status.
Multi, Checkboxes.
1: HMO/POS
2: PPO
3: EPO

18.1.2 Applicant must provide the NCQA or URAC accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply. If accredited by the Accreditation Association for Ambulatory Health Care (AAACH), provide accreditation status and expiration date in Details.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA HMO	*Single, Pull-down list.* 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Interim 6: In Process 7: Denied 8: Scheduled 9: Expired 10: NCQA not used or product not eligible	*To the day.*	

NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application 2: Interim 3: First 4: Renewal 5: NCQA Exchange not used	*To the day.*	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA 2: Accredited and NOT reporting measures 3: Did not participate	*To the day.*	
NCQA Managed Behavioral Health Organization Accreditation	*Single, Radio group.* 1: Full Accreditation 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	*To the day.*	
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used	*To the day.*	*50 words.*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used	*To the day.*	*50 words.*
NCQA Case Management Accreditation	*Single, Radio group.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	*To the day.*	*50 words.*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification	*To the day.*	*50 words.*

NCQA Multicultural Health Care Distinction	*Single, Radio group.* 1: Distinction 2: No MHC Distinction	*To the day.*	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	

18.1.3 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate, and upload as a file titled “Accreditation 1a” and including question number 18.1.3.

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

18.1.4 Applicant must provide the NCQA accreditation status and expiration date of the accreditation achieved for the PPO product identified in this response. Indicate all that apply.

For the URAC Accreditation option, enter each expiration date in the detail box if Applicant has earned multiple URAC accreditations.

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA PPO	*Single, Pull-down list.* 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Denied 6: In Process 7: Scheduled 8: Expired 9: NCQA not used or product not eligible	*To the day.*	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application 2: Interim 3: First 4: Renewal 5: NCQA Exchange not used	*To the day.*	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA 2: Accredited and NOT reporting measures 3: Did not participate	*To the day.*	*50 words*
NCQA Managed Behavioral Healthcare Accreditation	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	*To the day.*	*50 words*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented	*To the day.*	*50 words*

	3: Plan Oriented 4: NCQA not used		
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used	*To the day.*	*50 words*
NCQA Case Management Accreditation	*Multi, Checkboxes.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	*To the day.*	*50 words*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification	*To the day.*	
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction 2: No MHC Distinction	*To the day.*	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	

URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	

18.1.5 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title “Accreditation 1b” and including question number 18.1.5.

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

18.1.6 Applicant must provide the NCQA accreditation status and expiration date of the accreditation achieved for the EPO product identified in this response. Indicate all that apply. For the URAC Accreditation option, enter each expiration date in the detail box if Applicant has earned multiple URAC accreditations.

Details limited to 50 words.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA EPO	*Single, Pull-down list.* 1: Excellent 2: Commendable 3: Accredited 4: Provisional 5: Interim 6: Denied 7: In Process 8: Scheduled 9: Expired 10: NCQA not used or product not eligible	*To the day.*	
NCQA Exchange	*Single, Pull-down list.* 1: Completed Health Plan Add-On Application 2: Interim 3: First 4: Renewal 5: NCQA Exchange not used	*To the day.*	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to	*To the day.*	*50 words.*

	NCQA 2: Accredited and NOT reporting measures 3: Did not participate		
NCQA Managed Behavioral Healthcare	*Single, Radio group.* 1: Full Accreditation, 2: Accredited – 1 Year 3: Provisional Accreditation 4: Denied Accreditation 5: NCQA not used	*To the day.*	*50 words.*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented 2: Patient oriented 3: Plan Oriented 4: NCQA not used	*To the day.*	*50 words.*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design 2: Systems 3: Contact 4: NCQA not used	*To the day.*	*50 words.*
NCQA Case Management Accreditation	*Multi, Checkboxes.* 1: Accredited - 3 years 2: Accredited - 2 years 3: No accreditation	*To the day.*	*50 words.*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified 2: No PHQ Certification	*To the day.*	
NCQA Multicultural Health Care Distinction	*Single, Pull-down list.* 1: Distinction 2: No MHC Distinction	*To the day.*	
URAC Accreditations	*Single, Radio group.* 1: URAC used 2: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditation - Comprehensive Wellness	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	

URAC Accreditations - Disease Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Health Utilization Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Case Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	
URAC Accreditations - Pharmacy Benefit Management	*Single, Radio group.* 1: URAC Accredited 2: Not URAC Accredited	*To the day.*	

18.1.7 If Applicant indicated any accreditations above, provide a copy of the accrediting agency's certificate and upload as a file title “Accreditation 1c” and include question number 18.1.7.

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

18.2 Focus on High Cost Providers

Question required for currently contracted Applicants and new entrant Applicants.
Affordability is core to the Exchange’s mission to expand the availability of insurance coverage and promote the Triple Aim. The wide variation in unit price and total costs of care charged by providers, with some providers charging far more for care irrespective of quality, is a significant contributor to high cost of medical services. In this section, Applicants will be assessed on the extent to which there are activities in place to assess variation and prevent unduly high prices.

18.2.1 Describe Applicant’s efforts to understand price variation and strategies to ensure providers and hospitals do not charge unduly high prices. Specifically address each of the following in the response:

- The factors Applicant considers in assessing the relative unit prices and total costs of care
- The extent to which Applicant adjusts or analyzes the reasons for cost factors
- How cost factors are used in the selection of Providers and facilities in networks available to Enrollees
- Whether Applicant conducts analyses of its hospital networks, e.g. identifying specific hospitals with cost deciles and calculating percentage of costs expended in each cost decile

- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen this delivery system reform aim to improve affordability

500 words.

18.3 Demonstrating Action on High Cost Pharmaceuticals

Question required for currently contracted Applicants and new entrant Applicants.

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life-threatening conditions. At the same time, the Exchange is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. In this section, Applicants will be assessed on the extent to which value is considered in the construction of formularies and delivery of pharmacy services.

18.3.1 Describe Applicant's approach to achieving value in the delivery of pharmacy services and controlling drug costs as a percent of the total cost of care. Specifically address each of the following in the response:

- How Applicant considers value in its selection of medications for use in its formulary
- Indicate whether a value assessment methodology, such as the Drug Effectiveness Review Project (DERP) or ICER Value Assessment Framework (ICER-VF), or other independent reports are used by Applicant. If so, list methodologies used as well as how they are used to improve the value of pharmacy services.
- How decisions to select drugs and place them on tiers within the formulary are based on total cost of care rather than on drug cost alone
- Describe Applicant's strategy for specialty pharmacy and biologics management
- How Applicant provides decision support for prescribers and consumers in selecting appropriate, efficacious, high-value treatments and how Applicant alerts prescribers and consumers to more cost-effective alternatives when applicable If Applicant or Applicant's PBM is considering implementing a pharmacy order-entry decision support tool to promote value-based prescribing, and if so, indicate which tool Applicant is using
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would strengthen the Applicant's ability to address high cost pharmaceuticals

500 words.

18.4 Participation in Collaborative Quality Initiatives

All questions are required only for new entrant Applicants.

The Exchange believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support

clinicians and other providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by the Exchange, most notably Smart Care California, Partnership for Patients, and the California Maternal Quality Care Collaborative (CMQCC). The following questions address Applicant's current involvement in collaborative efforts. Applicants will be assessed based on the breadth and depth of their involvement.

18.4.1 Describe how Applicant is measuring overuse of Cesarean Sections, opioids, and low back pain imaging, and if it is aligning with Smart Care California guidelines to promote best practices of care in these areas.

100 words.

18.4.2 Identify key collaboratives and organizations in which Applicant is engaged and briefly explain how the Applicant participates. "Engagement" is defined as active participation through regular meeting attendance, health plan representatives serving as advisory members, providing funding, submitting data to the collaborative, or providing feedback on initiatives and projects.

Collaborative Quality Initiative *Select from drop-down menu.* 1. Smart Care California 2. Partnership for Patients 3. CMQCC 4. California Perinatal Quality Collaborative (CPQCC) 5. California Quality Collaborative (CQC) 6. Right Care Initiative 7. Other	Describe Participation *100 words.*

18.5 Data Exchange with Providers

All questions required for currently contracted Applicants and new entrant Applicants.

To be successful under Exchange Quality Improvement Strategy (QIS) requirements, and to improve the quality of care and successfully manage costs, successful Applicants will need to

encourage enhanced exchange of clinical data between providers. Participation in Health Information Exchanges (HIE) will enable notification of physicians when their patients are admitted to the hospital and allow contracted plans to track, trend and improve performance on conditions such as hypertension or diabetes control. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and current participation in regional and statewide initiatives to improve data exchange.

18.5.1 Describe Applicant's efforts to improve routine exchange of clinical data across specialties and institutional boundaries and between health plans and contracted providers. Specifically address each of the following:

- The extent to which data, other than claims information, is exchanged between providers and Applicant and the proportion of providers in the network that currently submit non-claims data (clinical, demographic, etc.) to Applicant or other providers
- Initiatives in place to improve routine exchange of data to improve the quality of care, such as notifying providers of hospital admissions, collecting clinical data to supplement annual HEDIS data collection, and race/ethnicity self-reported identity
- Whether Applicant requires contracted providers (hospitals, IPAs, medical groups, individual providers, etc.) to contribute data to HIEs or use HIE services and whether Applicant providers resources or incentives to providers to participate in HIEs
- Comment on potential collaboration opportunities, new statewide or regional initiatives, or other activities that would improve quality and manage costs through data exchange

500 words.

18.5.2 Identify the HIE initiatives and organizations in which Applicant is engaged and briefly explain how the Applicant participates. "Engagement" is defined as submitting data, receiving data, or providing funding.

Data Exchange Initiative *Select from drop-down menu.* 1. Central Coast Health Connect (CCHC) 2. LANES 3. Manifest MedEx 4. Marin Health Gateway 5. OCPRHIO 6. SacValley MedShare (merged with Connect Healthcare) 7. San Diego Health Connect 8. Santa Cruz Health Information Exchange 9. St. Joseph Health 10. Other	Describe participation including what data Applicant contributes (eligibility files, medical claims, pharmacy claims, etc.) and how often Applicant contributes data. *100 words.*

18.5.3 What is the core value Applicant is seeking from HIE participation?
Multi, Checkboxes.

- Improve care coordination
- Reduce burden of prior authorization and other provider/plan interactions
- Reduce readmissions
- Support population health efforts (risk stratification, enrollment in chronic care efforts, etc.)
- Improve HEDIS, risk adjustment and STARS performance
- Other: *Details limited to 100 words.*
- N/A Applicant does not participate in an HIE

18.6 Data Aggregation Across Health Plans

Question required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting. In this section, Applicant will be assessed on the extent to which it is engaging with other payers and stakeholders to support aggregation.

18.6.1 Identify the data aggregation initiatives in which the Applicant is engaged to support aggregation of claims or other information across payers.

Multi, Checkboxes.

- Integrated Health Association (IHA)Align Measure Perform (AMP) Commercial HMO program (formerly known as Value Based P4P)
- IHA Encounter Data Initiative,
- IHA Cost and Quality Atlas
- IHA Provider Directory Utility
- CalHospitalCompare
- CMQCC
- Other: *Details limited to 100 words.*

18.7 Mental and Behavioral Health Management

All questions required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes the critical importance of Mental and Behavioral Health Services as part of the broader set of medical services provided to enrollees. Answers will be evaluated based on the degree of integration and accessibility relative to industry trends and market innovations, as well as the thoroughness of the response.

18.7.1 a. Describe Applicant's mechanisms to ensure consumers access and receive appropriate, evidence-based treatment, including a description of methods to monitor mental and behavioral health services' quality, effectiveness, and cultural competency.
500 words.

b. Specify which measures are tracked (e.g., clinical measures, patient-reported experience, or others) to ensure consumers receive appropriate, evidence-based treatment and provide the outcomes for these measures for 2017 and 2018.

Measure *50 words.*	Outcome *50 words.*		
	2017	2018	2019 (to date)

18.7.2 Describe Applicant's strategies to improve accessibility of mental and behavioral health services. Specifically address the following efforts to improve the availability of services, such as changes in benefits management, networks, providing alternatives to face-to-face visits, etc.

- Explanation of consumer point of entry to behavioral health services

Methods to receive and address consumer concerns*500 words.*

18.7.3 Describe Applicant's strategies to further integrate mental and behavioral health with medical services. Specifically address each of the following:

- Describe Applicant's integrated behavioral health-medical model, if applicable. Indicate whether these efforts are implemented in association with Patient Centered Medical Home (PCMH) and Integrated Healthcare Models (IHM) models
- Percent of services provided under an integrated behavioral health-medical model, as defined and recognized by Applicant, in both its Exchange business (if Applicant had Exchange business in 2018) and total book of business
- How Applicant improves the integration of mental and behavioral health services and medical services, and a description of any recommended models or best practices integrating these services

- Comment on any innovative models in California or nationwide and potential collaborative opportunities to adopt these models on a larger scale

500 words.

18.8 Health Technology (Telehealth and Remote Monitoring)

Question required for currently contracted Applicants, rows 10 – 12, and 15. Question required for new entrant Applicants.

The Exchange supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. The following questions address Applicant's adoption and use of health technology, and answers will be evaluated based on Applicant's capacity for telehealth and remote monitoring relative to industry trends.

18.8.1 Provide information regarding Applicant's capabilities to support provider-member consultations using technology (e.g., web consultations, telemedicine). Applicant will be evaluated based on the availability of telehealth services for all books of business, particularly Exchange membership (if Applicant is not currently contracted with the Exchange, select "1" if the service would be offered to Exchange members, and include a description in the details section).
If no changes from previous Certification Application, currently contracted Applicants will only respond to rows 10, 11, 12, 15, and 16.

Note that Applicants selecting "Plan does not offer or allow web or telehealth consultations" will not complete the responses for all rows and columns in this question.

Details limited to 100 words.

Response	Answer	Technology	Details
1. Applicant ability to support web/telehealth consultations, either through a contractor or provided by the medical group/provider	*Multi, Checkboxes.* 1: Plan does not offer/allow web or telehealth consultations 2: Web visit using instant messaging 3: Telehealth with interactive face to face dialogue (video) over the Web 4: Telehealth		*20 words.*

	with interactive dialogue over the phone 5: Telehealth via email 6: Other (specify)		
2. Indicate availability of web/telehealth consultations, either through a contractor or provided by a medical group/provider, by book of business	*Multi, Checkboxes.* 1: Exchange 2: All large group 3: Large group buy-up option only 4: Medicaid 5: Medicare 6: Other		*20 words.*
3. Indicate availability of web/telehealth consultations, either through a contractor or provided by a medical group/provider, by product type	*Multi, Checkboxes.* 1: HMO 2: PPO 3: EPO 4: Other		*20 words.*
4. Applicant uses a vendor for web/telehealth consultations (indicate vendor and average wait time in the answer section)	*50 words.* N/A OK.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant	*20 words.*

		messaging 5: Email 6: Other (specify)	
5. Applicant contracts with medical groups/providers that offer web/telehealth consultations (yes/no with details)	*50 words* N/A OK	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
6. If physicians and/or physician groups/practices are designated in provider directory as having web/telehealth consultation services available, provide percentage of physicians in the network (across all lines of business)	*Percent.* From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
7. For physicians that are available to deliver web/telehealth consultations, what is the average wait time? If Applicant can provide average wait time	*Single, Radio group.* N/A OK. 1: On demand 2: Within 4	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web	*20 words.*

- describe how that is monitored in detail box at end of question	hours 3: Within same day 4: Scheduled follow-up within 48 hours 5: Other (describe)	(video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	
8. Applicant promotes telehealth (either through vendor or medical group) as an alternative to the ED for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups)	*50 words.* N/A OK.		*20 words.*
9. Member reach of physicians providing web/telehealth consultations (i.e. what % of members are attributed to those physicians offering web/telehealth consultations) (use as denominator total membership across all lines of business). If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Percent.* From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
10. What percentage of the current total membership has access to web/telehealth consultations as a covered core benefit (no buy-up required)? (Use as denominator total membership across all lines of business).	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth	*20 words.*

		via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	
11. Percentage of unique members with a web/telehealth consultation in 2018	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
12. If Applicant had Exchange business in 2018: Percentage of unique Exchange members with a web/telehealth consultation in 2018	*Percent.* N/A OK. From 0 to 100.	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email	*20 words.*

		6: Other (specify)	
13. Applicant reimburses for web/telehealth consultations	*Single, Radio group.* 1: Yes 2: No	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
14. Among members in plans with available web/telehealth consultation, what is the member cost share?	*Multi, Checkboxes.* 1: No cost share 2: Same cost as a primary care visit 3: Same cost as a specialist visit 4: Telehealth visit cost share (explain): 5: Other (explain):	*Multi, Checkboxes.* N/A OK. 1: Telehealth via web (video) 2: Telehealth via phone 3: Combination of web (video) and phone 4: Instant messaging 5: Email 6: Other (specify)	*20 words.*
15. Discuss how the Applicant balances encouraging members to use telehealth options while promoting integration and coordination of care	*200 words.*		
16. Discuss any innovations or pilot programs adopted by Applicant that are not reflected in this table (such as plans	*100 words.* N/A OK.		

for new programs, expansion of existing programs, new telehealth features, etc.)			

18.9 Health and Wellness

All questions are required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of enrollee health. The following questions address Applicant's ability to track the health and wellness of enrollees and identify enrollees for preventive care and interventions. Answers will be evaluated based on the degree to which health and wellness data is tracked on membership and used to coordinate care.

18.9.1 Report selected measures below for the two most recently calculated years of HEDIS results for the HMO Applicant (QC 2018 and 2017).

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	HMO QC 2018	QC 2017, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.2 Report selected measures below for the two most recently calculated years of HEDIS results for the PPO Applicant (QC 2018 and 2017).

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

coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	PPO QC 2018	PPO QC 2017, or prior year's PPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.3 Report selected measures below for the two most recently calculated years of HEDIS results for the EPO Applicant (QC 2018 and 2017).

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	EPO QC 2018	EPO QC 2017, or prior year's EPO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.4 Which of the following member interventions were used by Applicant in calendar year 2018 to improve cancer screening rates? Indicate all that apply.

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

18.9.5 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for HMO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	QC 2018, or most current year's HMO result	QC 2017, or prior year's HMO QC result

Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.6 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for PPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'.

	QC 2018, or most current year's PPO result	QC 2017, or prior year's PPO QC result
Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents – Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.7 Report selected measures below for the two most recently uploaded years of HEDIS/CAHPS (QC 2018 and QC 2017) results for EPO Applicant.

If Applicant did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised: -1 means 'NR', -2 means 'NA', -3 means 'ND', -4 means 'EXC', and -5 means 'NB'

	QC 2018, or most current year's EPO result	QC 2017, or prior year's EPO QC result
Childhood Immunization Status - Combo 3	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents – Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
CAHPS Flu Shots for Adults (18-64) (report rolling average)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

18.9.8 Identify member interventions used in calendar year 2018 to improve immunization rates. Check all that apply.

	Response	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Childhood Immunizations	*Multi, Checkboxes.* 1: General education (i.e. - member	*Single, Radio group.* 1: Available to >	*Single, Radio group.* 1: Available to > 75% of members

	newsletter) 2: Community/employer immunization events 3: None of the above	75% of members 2: Available to < 75% of members 3: Not available	2: Available to < 75% of members 3: Not available
Immunizations for Adolescents	*Multi, Checkboxes.* 1: General education (i.e. - member newsletter) 2: Community/employer immunization events 3: None of the above	*Single, Radio group.* 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available	*Single, Radio group.* 1: Available to > 75% of members 2: Available to < 75% of members 3: Not available

18.9.9 Indicate whether Applicant currently participates in the California Immunization Registry (both submitting and receiving data). If yes, include a description of how Applicant uses the data obtained in the registry, e.g. supporting outreach to those with gaps in care and/or evaluating effectiveness of provider interventions.

Single, radio group
1: Yes (explain) *(50 words)*
2: No

Details limited to 100 words.

18.9.10 Indicate the number and percent of tobacco-dependent commercial members identified and participating in cessation activities during 2018.

If Applicant is currently contracted with the Exchange, provide <u>Exchange</u> counts if available. If Exchange counts are not available, provide state or regional counts.

	Answer
Indicate how Applicant identifies members who use tobacco. Applicant may add up the tobacco users identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on number of commercial members individually identified as tobacco dependent in 2018.	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)

Indicate ability to track identification of tobacco-dependent members. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally, 2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of tobacco-dependent members in cessation activities. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members individually identified as tobacco dependent in 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000
% of California members identified as tobacco dependent (Calculated as number of California members individually identified as tobacco dependent divided by total California membership)	*Percent*
Number of Exchange members individually identified as tobacco dependent in 2018.	*Decimal.* From 0 to 1000000000
% of Exchange members identified as tobacco dependent (Calculated as number of Exchange members individually identified as tobacco dependent divided by total Exchange membership)	*Percent*
Number of California members identified as tobacco dependent who participated in a smoking cessation program	*Decimal.* From 0 to 1000000000

during 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	
Of California members identified as tobacco dependent, what percent are participating in smoking cessation program (Number of program participants divided by number of identified smokers)?	*Percent.*
Number of Exchange members identified as tobacco dependent who participated in a smoking cessation program during 2018.	*Decimal.* From 0 to 1000000000.
Of Exchange members identified as tobacco dependent, what percent are participating in smoking cessation program (Number of program participants divided by number of identified smokers)?	*Percent.*

18.9.11 Indicate the number of obese members identified and participating in weight management programs during 2018. Do not report general prevalence.

If Applicant is currently contracted with the Exchange, provide Exchange counts if available. If Exchange counts are not available, provide state/regional counts.

	Answer
Indicate how Applicant identifies members who are obese. Applicant may add up the obese members identified in each of the ways identified in this row with the recognition that this may result in some duplication or over counting in response to row below on Number of commercial members individually identified as obese in 2018 as of December 2018	*Multi, Checkboxes.* 1: Plan Health Assessment, 2: Employer/Vendor Health Assessment, 3: Member PHR, 4: Claims/Encounter Data, 5: Disease or Care Management, 6: Wellness Vendor, 7: Other (describe in box in cell)
Indicate ability to track identification of obese members. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked statewide & regionally,

	2: Identification only tracked statewide, 3: Identification only tracked regionally, 4: Identification not tracked regionally/statewide, 5: Identification can be tracked at Covered California level
Indicate ability to track participation of obese members in weight management programs. Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked statewide & regionally, 2: Participation tracked only statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of California members identified as obese in 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.
% of California members identified as obese (Calculated as number of California members individually identified as obese divided by total California membership)	*Percent.*
Number of Exchange members identified as obese in 2018.	*Decimal.* From 0 to 1000000000.
% of Exchange members identified as obese (Calculated as number of Exchange members individually identified as obese divided by total Exchange membership)	*Percent.*
Number of California members identified as obese who participated in a weight management program during 2018. (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 1000000000.
Of California members identified as obese, what percent are participating in a weight management program (Number of program participants divided by number of identified obese)?	*Percent.*

Number of Exchange members identified as obese who participated in weight management program during 2018.	*Decimal.* From 0 to 1000000000.
Of Exchange members identified as obese, what percent are participating in a weight management program (Number of program participants divided by number of identified obese)?	*Percent.*

18.9.12 As part of total population management and person-centered care, summarize Applicant activities and ability to identify members who are non-users (no claims) and engage those members in staying or becoming healthy.

	Response/Summary	Geography of response
Percent of total commercial membership with no claims in CY 2018	*Percent.* N/A OK.	*Single, Radio group.* 1: Regional 2: State
Summary (bullet points) of plan activities to engage members who are non-users	*100 words.* N/A OK.	

18.9.13 Indicate capabilities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.

Multi, Checkboxes.
1: HA Accessibility: Both online and in print.
2: HA Accessibility: IVR (interactive voice recognition system).
3: HA Accessibility: Telephone interview with live person.
4: HA Accessibility: Multiple language offerings.
5: HA Accessibility: HA offered at initial enrollment.
6: HA Accessibility: HA offered on a regular basis to members.
7. Applicant does not offer an HA.

18.9.14 Indicate activities supporting Applicant's Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Check all that apply.

Multi, Checkboxes. Not required if answered 7 to 18.9.13.
1. Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to member based on member-specific risk, e.g. at point of “smoking-yes” response, tobacco cessation education is provided as pop-up.
2: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses.
3: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion.
4: Addressing At-risk Behaviors: Ongoing push messaging for self-care based on member's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member).
5: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses.
6: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results.
7: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician.
8: Addressing At-risk Behaviors: Member can update responses and track against previous responses.
9: Tracking health status: HA responses incorporated into member health record.
10: Tracking health status: HA responses tracked over time to observe changes in health status.
11: Tracking health status: HA responses used for comparative analysis of health status across geographic regions.
12: Tracking health status: HA responses used for comparative analysis of health status across demographics.
13: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results.
14: Partnering with Employers: Health plan can import data from employer-contracted HA vendor.

18.9.15 Provide the number of currently enrolled commercial and Exchange members who completed a Health Assessment (HA) in the past year.

	Answer
Geography reported below for HA completion Select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* *If option 4 selected, responses to the following questions in the table are not required.* 1: Participation tracked statewide & regionally,

	2: Participation only tracked statewide, 3: Participation only tracked regionally, 4: Participation not tracked regionally/statewide, 5: Participation can be tracked at Covered California level
Number of members completing Plan-based HA in 2018 (If Applicant has and tracks use by Medi-Cal members as well, number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Percent HA completion (Health plan HA completion number divided by total enrollment)	Percent.
Number of completed HAs resulting in referral to health plan case management staff or assigned provider	*Decimal.*
Percent completed HAs resulting in referral to health plan case management staff or assigned provider (Referral number divided by number of completed HAs)	Percent.

18.9.16 Does Applicant collect information, at both individual and aggregate levels, on changes in enrollees' health status? Describe Applicant's process to monitor and track changes in enrollees' health status, which may include its process for identifying individuals who show a decline in health status.

100 words.

18.9.17 Does Applicant refer enrollees with a change in health status to care management and chronic condition program(s)? Include in the answer how many Exchange enrollees, across all products, have been identified through the process and referred to care management, chronic condition program(s), or other services due to a change in health status in 2018. If Applicant does not currently have Exchange business, report on all lines of business.

100 words.

18.10 Community Health and Wellness Promotion

Question required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments, and the promotion of healthy behaviors across the community. The following question addresses Applicant's activities to promote better community health, and answers will be evaluated based on the degree to which Applicant's programs are external-facing (i.e. the activity or program has an expected impact on community health, rather than solely for Applicant's members).

18.10.1 Provide a description of the external-facing initiatives, programs and projects Applicant supports to promote better community health, and how such programs specifically address health disparities or efforts to improve community health apart from the health delivery system. Examples include the California Reducing Disparities Project (CRDP), Health in All Policies (HIAP), The California Endowment Healthy Communities, and Beach Cities Health District, among others. Please note the definition of external-facing provided in the previous paragraph and include any evaluation results of the activity or program, if available.

500 words.

18.11 At-Risk Enrollees

All questions are required for currently contracted Applicants and new entrant Applicants.

The Exchange recognizes that identifying and proactively managing at-risk Enrollees, defined as individuals with existing and newly diagnosed chronic conditions, such as diabetes, heart disease, asthma, hypertension or a medically complex condition, serves to better coordinate care, which improves outcomes and lowers costs. The following questions assess Applicant's ability to track and manage these enrollees, and responses will be evaluated on Applicant's use of data and interventions to proactively manage enrollees as well as the thoroughness of the response.

18.11.1 How does Applicant identify at-risk enrollees who would benefit from early, proactive interventions? Describe applicable diseases for at-risk identification, sources of data, and any predictive analytic capabilities.

100 words.

18.11.2 For the Exchange business, Applicant must provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above identified under Applicant's criteria for at-risk enrollees eligible for case management in the second row. If Applicant does not currently have Exchange business, report on all lines of business excluding Medicare.

	Number of members as specified in rows 1, and 2

Number of members aged 18 and above in this state or market	*Decimal.*
Using Applicant's definition, provide number of members 18 and above who are at-risk enrollees	*Decimal.*

18.11.3 Describe outreach and interventions used to ensure at-risk enrollees get needed care. Note if any of the strategies below are used and indicate whether the program is specific to at-risk enrollees or a program for all enrollees.

- Member-specific reminders for due or overdue clinical/diagnostic maintenance services and/or medication events (failure to refill for example)
- Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between Applicant and the member
- Self-initiated text/email
- Interactive IVR
- Live outbound telephonic coaching program
- Face to face visits

500 words.

18.11.4 Describe Applicant's process for keeping and updating a medical history of at-risk enrollees in its maintained enrollee health profile.

65 words.

18.11.5 Does Applicant share registries of enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable providers, especially the enrollee's PCP? If yes, describe.

Single, Radio group.
1: Yes, describe: [65 words]
2: No

18.11.6 Describe the mechanisms to evaluate access within the provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for at-risk enrollees.

100 words.

18.11.7 Describe Applicant's ability to gather, categorize, and package current information on at-risk enrollees in case Applicant is requested to transfer its enrollees to other Exchange health plans to facilitate a smooth transition of care.
100 words.