## Appendix 2 to Attachment 7: Measurement Specifications

QHP Issuers shall use the following metrics to establish baseline measurements for Attachment 7 requirements and demonstrate improvement on each of these measurements over time. These metrics were reported in the 2017 Application for Certification and must be reported according to the table below. Additionally, QHP Issuers must report these metrics as necessary upon Covered California's request. Covered California and QHP Issuers shall work collaboratively during the term of this Agreement to enhance these specifications to further define the requirements.

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| 1 | 3.01(a)(i) | Self-Reported Racial and Ethnic Identity | Report members self-identifying racial and ethnic group through the enrollment application, web site registration, health assessment, reported at provider site, etc. | Members self-identifying racial and ethnic group | Total membership (all lines of business excluding Medicare) | Administrative Data (enrollment) | Annually | 2017, 2018, and 2019 Applications for Certification - QIS |
| 2 | 3.01(a)(ii) | Racial and Ethnic Identity | Report racial and ethnic identity based on self-report or proxy methodology (i.e. zip code or surname analysis, or both) | Members with racial and ethnic group identified | Total membership (all lines of business excluding Medicare) | Administrative Data (enrollment) | Annually | 2017, 2018, and 2019Application for Certification - Covered California eValue8 RFI |
| 3 | 3.01(b)(i) | IHA #7 – Diabetes Care: HbA1c Control < 8.0% | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | Refer to IHA MY 2016 P4P Clinical Specifications: Diabetes Care | Refer to IHA MY 2016 P4P Clinical Specifications: Diabetes Care | Claim/ encounter or automated laboratory data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 4 | 3.01(b)(i) | CBP – Controlling High Blood Pressure | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | Refer to HEDIS specifications for measure description and eligible population | Refer to HEDIS specifications for measure description and eligible population | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 5 | 3.01(b)(i) | IHA #28 – Asthma Medication Ratio Ages 5-85 | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | Refer to IHA MY 2016 P4P Clinical Specifications: Asthma Medication Ratio | Refer to IHA MY 2016 P4P Clinical Specifications: Asthma Medication Ratio | Claim/ encounter and pharmacy data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 6 | 3.01(b)(i) | AMM – Antidepressant Medication Management | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American | Refer to HEDIS specifications for measure description and | Refer to HEDIS specifications for measure description and | Claim/ encounter and pharmacy data | Annually | 2017, 2018, and 2019 Application for |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| | | | • Hispanic or Latino<br>• White, not Hispanic or Latino | eligible population | eligible population | | | Certification - QIS |
| 7 | 3.01(b)(i) | Hospital Admission Rate for Diabetes | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | Hospital admissions for any reason excluding trauma among members with diabetes (use HEDIS eligible population definition for diabetes) | Members with diabetes (use HEDIS eligible population definition for diabetes) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 8 | 3.01(b)(i) | ED Admission Rate for Diabetes | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | ED admissions for any reason excluding trauma among members with diabetes (use HEDIS eligible population definition for diabetes) | Members with diabetes (use HEDIS eligible population definition for diabetes) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 9 | 3.01(b)(i) | Hospital Admission Rate for Hypertension | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | Hospital admissions for any cardiovascular diagnosis (heart failure, CAD, stroke) or renal failure comorbid or due to hypertension | Members identified as hypertensive (use HEDIS eligible population definition) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 10 | 3.01(b)(i) | ED Admission Rate for Hypertension | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | ED admissions for any cardiovascular diagnosis (heart failure, CAD, stroke) or renal failure comorbid or due to hypertension | Members identified as hypertensive (use HEDIS eligible population definition) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 11 | 3.01(b)(i) | Hospital Admission Rate for Asthma | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino | Hospital admissions for pulmonary diagnoses among members | Members with asthma (use HEDIS eligible population for asthma) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| | | | • White, not Hispanic or Latino | with asthma (use HEDIS eligible population for asthma) | | | | |
| 12 | 3.01(b)(i) | ED Admission Rate for Asthma | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | ED admissions for pulmonary diagnoses among members with asthma (use HEDIS eligible population for asthma) | Members with asthma (use HEDIS eligible population for asthma) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 13 | 3.01(b)(i) | ED Admission Rate for Depression | Report rates by race/ethnicity:<br>• Asian/Native Hawaiian or other Pacific Islander<br>• Black or African American<br>• Hispanic or Latino<br>• White, not Hispanic or Latino | ED admissions among members with depression (use HEDIS eligible population for members with a diagnosis of major depression) | Members with a diagnosis of major depression (use HEDIS eligible population) | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 14 | 4.01 | Primary Care Physician Selection | Report members by product in the health plan's Covered California business with a personal care physician (PCP) | Number of Covered California members who have selected or were assigned to a PCP | Total Covered California membership | Administrative data | Quarterly | 2017, 2018, and 2019 Application for Certification - QIS / quarterly reports as requested |
| 15 | 4.02 | Primary Care Payment Strategies | Report the number and percentage of California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics | Number of California members attributed to a provider with a payment reform strategy | Total California membership | Administrative/ financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 16 | 4.02 | Primary Care Payment Strategies | Report the number and percentage of Covered California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics | Number of Covered California members attributed to a provider with a payment reform strategy | Total Covered California membership | Administrative/ financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 17 | 4.03 | Membership Attributed to IHMs | Within QIS report for existing or planned integrated systems of care, report the number | Number of California members | Total California membership | Administrative/ financial data | Annually | 2017, 2018, and 2019 Application for |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| | | | and percentage of California members in each product who are managed under an IHM | managed under an IHM | | | | Certification - QIS |
| 18 | 4.03 | Membership Attributed to IHMs | Within QIS report for existing or planned integrated systems of care, report the number and percentage of Covered California members in each product who are managed under an IHM | Number of Covered California members managed under an IHM | Total Covered California membership | Administrative/ financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 19 | 5.01 | Hospitals reporting to CMQCC | Report hospital participation in CMQCC | Number of network hospitals reporting to CMQCC | Total number of hospitals providing maternity services in network | Network data/CMQCC participant list | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 20 | 5.01 | Hospitals meeting CalSIM goal for C-sections | Report hospital network performance for meeting CalSIM NTSV C-Section goal | Number of hospitals meeting CalSIM goal of NTSV C-Section rate at or below 23.9 percent | Total number of hospitals providing maternity services in network | Network data/clinical data submitted to CMQCC | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 21 | 5.01 | NTSV C-Section rate for each network hospital | For the plan's network of hospitals providing maternity services, report each hospital name, location, product network (HMO, PPO, EPO), and NTSV C-Section rate | Total number of NTSV C-Section deliveries | Total number of NTSV deliveries | Network data/clinical data submitted to CMQCC | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 22 | 5.01 | Payment strategies for maternity services | Report number of hospitals paid under each type of payment strategy for maternity services and the denominator (total number of network hospitals) | Number of hospitals paid under payment strategy or each payment strategy | Total number of network hospitals providing maternity services | Network data/financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 23 | 5.02 | Excessive Anticoagulation among Inpatients Receiving Warfarin (INR >5.0) | Report rate for each network hospital:<br><br>Anticoagulation-associated adverse drug event (ADE) caused by medical error and/or adverse drug reactions<br><br>Rate Calculation: (Numerator / Denominator) x 100<br><br>Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data) | All inpatients experiencing excessive (INR > 5.0) anticoagulation with warfarin after 24 hours of admission | Inpatients receiving warfarin anticoagulation therapy | Clinical data (medical record review, incident reporting systems, laboratory reporting systems) reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 24 | 5.02 | Hypoglycemia in Inpatients | Report rate for each network hospital: | Hypoglycemia (<50.0) in | Inpatients receiving insulin | Clinical data (medical record | Annually | 2017, 2018, and 2019 |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| | | Receiving Insulin (Blood Glucose ≤ 50.0) | Diabetes-related ADE in the inpatient setting<br><br>Rate Calculation: (Numerator / Denominator) x 100<br><br>Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data) | inpatients receiving insulin or other hypoglycemic agents | or other hypoglycemic agents | review, incident reporting systems) reported to CMS | | Application for Certification - QIS |
| 25 | 5.02 | Opioid Adverse Events (Patients Treated with Naloxone) | Report rate for each network hospital:<br><br>Opioid-related ADE caused by medical error and/or adverse drug reactions<br><br>Rate Calculation: (Numerator / Denominator) x 100<br><br>Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data) | Number of inpatients treated with an opioid who received naloxone | Number of inpatients who received an opioid (top 5-10 prescribed) | Clinical data (medical record review, incident reporting systems, pharmacy reporting system) reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 26 | 5.02 | CAUTI Rate | Report rate for each network hospital:<br><br>CAUTI Rate – All Tracked Units  - to evaluate improvement<br><br>Rate Calculation: (Numerator / Denominator) x 1,000<br><br>Target-Setting Approach: Twelve months historical data for baseline | Number of inpatient healthcare-associated CAUTIs for all tracked units | Number of inpatient indwelling urinary catheter days for all tracked units | National Healthcare Safety Network (NHSN) or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 27 | 5.02 | CAUTI SIR | Report rate for each network hospital:<br><br>CAUTI  Standardized Infection Ration (SIR) – All Tracked Units – Relative performance<br><br>Rate Calculation: Numerator / Denominator<br><br>Target-Setting Approach: Twelve months historical data for baseline | Number of observed inpatient healthcare-associated CAUTIs for all tracked units | Number of predicted inpatient healthcare-associated CAUTIs for all tracked units (determined by NHSN) | NHSN or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| 28 | 5.02 | Urinary Catheter Utilization Ratio | Report rate for each network hospital:<br><br>Urinary Catheter Utilization Ratio – All Tracked Units<br><br>Rate Calculation: (Numerator / Denominator) x 100<br><br>Lower ratios are generally associated with better performance and may also impact the CAUTI rate | Number of inpatient indwelling urinary catheter days for all tracked units | Number of inpatient bed days for all tracked units | NHSN or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 29 | 5.02 | CLABSI Rate | Report rate for each network hospital:<br><br>CLABSI Rate – All Tracked Units<br><br>Rate Calculation: (Numerator / Denominator) x 1,000<br><br>Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | Number of observed inpatient healthcare-associated CLABSIs for all tracked units | Number of inpatient central line days for all tracked units | NHSN, California Department of Public Health (CDPH), or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 30 | 5.02 | CLABSI SIR | Report rate for each network hospital:<br><br>CLABSI SIR – All Tracked Units<br><br>Rate Calculation: Numerator / Denominator<br><br>Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | Number of observed inpatient CLABSIs for all tracked units | Number of expected inpatient CLABSIs for all tracked units (determined by NHSN) | NHSN, CDPH, or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 31 | 5.02 | Central Line Utilization Ratio | Report rate for each network hospital:<br><br>Central Line Utilization Ratio – All Tracked Units<br><br>Rate Calculation: (Numerator / Denominator) × 100<br><br>Lower ratios are generally associated with better performance and may also impact the CLABSI rate | Number of inpatient central line days for all tracked units | Number of inpatient bed days for all tracked units | NHSN, CDPH, or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 32 | 5.02 | C. Diff Rate | Report rate for each network hospital:<br><br>Lab-Identified C. Diff Rate | Number of inpatient hospital-onset C. diff lab identified | Number of inpatient bed days for all tracked units | NHSN, CDPH, or Partnership for Patients | Annually | 2017, 2018, and 2019 Application for |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| | | | Rate Calculation: (Numerator / Denominator) × 1,000<br><br>Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | events for all tracked units | | data reported to CMS | | Certification - QIS |
| 33 | 5.02 | C. Diff SIR | Report rate for each network hospital:<br><br>Lab-Identified C. Diff SIR<br><br>Rate Calculation: Numerator / Denominator<br><br>Target Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | Number of observed inpatient hospital-onset C. diff lab identified events for all tracked units | Number of expected inpatient hospital-onset cases of C. diff for all tracked units | NHSN, CDPH, or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 34 | 5.02 | SSI-Colon Rate | Report rate for each network hospital:<br><br>Colon Surgery SSI Rate<br><br>Rate Calculation: (Numerator / Denominator) × 100<br><br>Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | Number of SSIs related to colon surgeries (based on NHSN definition) | Inpatients having the colon procedures included in the NHSN operative procedure category | NHSN, CDPH, or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 35 | 5.02 | SSI-Colon SIR | Report rate for each network hospital:<br><br>Colon Surgery SSI SIR<br><br>Rate Calculation: Numerator / Denominator<br>Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH) | Number of observed SSIs for colon surgeries (based on NHSN definition) | Number of predicted SSIs for colon surgeries (determined by NHSN definition) | NHSN, CDPH, or Partnership for Patients data reported to CMS | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 36 | 5.03 | Hospital Reimbursement at Risk for Quality Performance | Report the percentage of hospital performance at risk for quality performance (metrics may include but are not limited to HACs, readmissions, patient satisfaction, etc.) | Hospital payment dollars tied to quality performance | Total hospital payment dollars | Financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |
| 37 | 5.03 | Hospitals with Reimbursement at Risk for Quality Performance | Report the number and percentage of hospitals with reimbursement at risk for quality performance (metrics may include but are not limited to HACs, readmission, patient satisfaction, etc.) | Hospitals with payment tied to quality performance | Total number of network hospitals | Network data/financial data | Annually | 2017, 2018, and 2019 Application for Certification - QIS |

| Metric No. | 2017 Contract Section | Measure Name | Description | Numerator | Denominator | Data Source | Reporting Frequency | Reporting Method |
|---|---|---|---|---|---|---|---|---|
| 38 | 6.01 | Members Using Wellness Benefit | Report the number and percentage of members who have a preventive care visit ($0 member cost share) | Members incurring at least one preventive care visit/service | Total membership across all lines of membership excluding Medicare | Claim/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification |
| 39 | 6.01 | Members identified as obese who are participating in a weight management program | Report the number of obese members who are participating in weight management programs | Number of California members identified as obese who are participating in weight management program | California members identified as obese | Claims/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI |
| 40 | 6.01 | Members identified as tobacco dependent who are participating in a smoking cessation program | Report the number of tobacco-dependent members who are participating in smoking cessation programs | California members identified as tobacco dependent participating in smoking cessation program | California members identified as tobacco dependent | Claims/ encounter data | Annually | 2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI |