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 or in subsequent data requests 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 Measurement Period	Reporting Method
1	3.01	Self-Reported Racial and or Ethnic Identity	Report members self-identifying racial and ethnic group through the enrollment application, web site registration, health assessment, reported at provider site, etc.	Covered California mMembers enrolled during the applicable Plan Year who self-identifying identified a racial and or ethnic group.	Total Covered California membership (all lines of business excluding Medicare) for the applicable Plan Year. Exclude members actively selecting an option to decline self-report (e.g. "decline to state" or "prefer not to say").	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Applications for Certification - QIS
2	3.01	Racial and or Ethnic Identity	Report racial and ethnic identity based on self-report or proxy methodology (i.e. zip code or surname analysis, or both)	Covered California mMembers enrolled during the applicable Plan Year with racial and ethnic group identified	Total Covered California membership (all lines of business excluding Medicare) for the applicable Plan Year	Administrative Data (enrollment)	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI
3	3.01	Diabetes Care: HbA1c Control < 8.0% (NQF 0575)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Report rates by Rraciale or ethnic /ethnicitygroup: ▪ Asian, /Native Hawaiian or other Pacific Islander ▪ Black or African American ▪ Hispanic or Latino ▪ White, not Hispanic or Latino	Refer to HEDIS QRS numerator administrative specificationss for HbA1c Control <8.0% measure description and eligible population	Refer to HEDIS QRS eligible population specifications for measure description and eligible populationfor Comprehensive Diabetes Care (NQF 0731)	Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
4	3.01	CBP – Controlling	Report rates by all lines of business excluding	Refer to	Refer to	Clinical data	Annually	January 1 –	2017, 2018,

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
		High Blood Pressure (NQF 0018)	Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ Report rates by race/ethnicity: ▪ Asian, /Native Hawaiian or other Pacific Islander ▪ Black or African American ▪ Hispanic or Latino ▪ White, not Hispanic or Latino	~~HEDIS~~QRS numerator specifications for ~~measure description and eligible population~~Controlling High Blood Pressure	~~HEDIS~~QRS eligible population specifications for ~~measure description and eligible population~~Controlling High Blood Pressure			December 31 of applicable measurement year	and 2019 Application for Certification - QIS
5	3.01	Asthma Medication Ratio Ages 5-85 (NQF 1800)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ Report rates by race/ethnicity: ▪ Asian, /Native Hawaiian or other Pacific Islander ▪ Black or African American ▪ Hispanic or Latino ▪ White, not Hispanic or Latino	~~Refer to~~ HEDIS numerator specifications for ~~measure description and eligible population~~Asthma Medication Ratio	~~Refer to~~ HEDIS eligible population specifications for ~~measure description and eligible population~~Asthma Medication Ratio	Administrative and clinical data	Annually	January 1 – December 31 of applicable measurement year and prior measurement year	2017, 2018, and 2019 Application for Certification - QIS
6	3.01	Antidepressant Medication Management (NQF 0105)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ Asian, Native Hawaiian or other Pacific Islander ▪ Black or African American ▪ Hispanic or Latino ▪ White, not Hispanic or Latino	QRS numerator specifications for Antidepressant Medication Management	QRS eligible population specifications for Antidepressant Medication Management	Pharmacy data	Annually	May 1 of prior measurement year – April 30 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~6~~7	3.01	~~~~Depression Response at Twelve Months- Progress Towards Remission ~~–~~ (NQF 1885)	Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender • Racial or ethnic group: ▪ Report rates by race/ethnicity: ▪ Asian, /Native Hawaiian or other Pacific Islander ▪ Black or African American ▪ Hispanic or Latino ▪ White, not Hispanic or Latino	~~Refer to~~ MN Community Measurement specifications for ~~measure description and eligible population~~numerator	~~Refer to~~ MN Community Measurement specifications for ~~measure description and eligible population~~denominator	Clinical data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~7~~8	3.01	~~Uncontrolled Diabetes Admission Rate (PQI 14) – NQF #~~	Combine the following AHRQ PQI measures for the Diabetes Hospitalization Hybrid Measure: • PQI #1 – Diabetes Short-Term	Combine ~~Refer to~~ AHRQ measure numerator specifications for	QRS eligible population specifications for Comprehensive Diabetes Care	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method

		~~0638~~Diabetes Hospitalization Hybrid Measure	Complications Admissions Rate
			• PQI #3 – Diabetes Long-Term Complications Admissions Rate
			• PQI #14 - Uncontrolled Diabetes Admission Rate
			• PQI #16 – Lower-Extremity Amputation among Patients with Diabetes Rate
			
			Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories:
			• Gender
			• Racial or ethnic group:
			  • ~~Apply only to members with diabetes.~~
			  ~~Report rates by race/ethnicity:~~
			  ▪ Asian, /Native Hawaiian or other Pacific Islander
			  ▪ Black or African American
			  ▪ Hispanic or Latino
			  ▪ White, not Hispanic or Latino
				~~numerator description.~~PQI #1, 3, 14, 16	~~(NQF 0731) Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for diabetes.~~				

~~8~~	~~3.01~~	~~ED Visit Rate for Diabetes~~	~~Report rates by race/ethnicity:~~ ~~• Asian/Native Hawaiian or other Pacific Islander~~ ~~• Black or African American~~ ~~• Hispanic or Latino~~ ~~• White, not Hispanic or Latino~~ ~~• Unknown~~	~~ED visits for any reason excluding trauma among members with diabetes (use HEDIS eligible population definition for diabetes)~~	~~Members with diabetes (use HEDIS eligible population definition for diabetes)~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~
~~9~~9	3.01	~~Hospital Admission Rate for Hypertension~~Hypertension Hospitalization Hybrid Measure	Combine the following AHRQ PQI measures for the Hypertension Hospitalization Hybrid Measure: • PQI #7 – Hypertension Admission Rate • PQI #8 – Heart Failure Admission Rate • PQI #13 – Angina Without Procedure Admission Rate Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories: • Gender	Combine AHRQ measure numerator specifications for PQI #7, 8, 13Hospital admissions for any cardiovascular diagnosis (heart failure, CAD, stroke)[1] or renal failure comorbid	QRS eligible population specifications for Controlling High Blood PressureMembers identified as hypertensive (use HEDIS eligible population definition)	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method

			• Racial or ethnic group:
			   • Report rates by race/ethnicity:
			   ▪ Asian, /Native Hawaiian or other Pacific Islander
			   ▪ Black or African American
			   ▪ Hispanic or Latino
			   ▪ White, not Hispanic or Latino
				or due to hypertension					

~~10~~	~~3.01~~	~~ED Visit Rate for Hypertension~~	~~Apply only to members with hypertension.~~ ~~Report rates by race/ethnicity:~~ • ~~Asian/Native Hawaiian or other Pacific Islander~~ • ~~Black or African American~~ • ~~Hispanic or Latino~~ • ~~White, not Hispanic or Latino~~ • ~~Unknown~~	~~ED admissions for any cardiovascular diagnosis (heart failure, CAD, stroke)[2] or renal failure comorbid or due to hypertension~~	~~Members identified as hypertensive (use HEDIS eligible population definition)~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~

~~11~~10	3.01	~~Asthma in Younger Adults Admission Rate (PQI 15) – NQF# 0283~~Asthma Hospitalization Hybrid Measure	Combine the following AHRQ PQI measures for the Hypertension Hospitalization Hybrid Measure:
			• PQI #5 COPD or Asthma in Older Adults Admission Rate
			• PQI #11: Bacterial Pneumonia Admission Rate
			• PQI 15 Asthma in Younger Adults Admission Rate
			
			Report rates by all lines of business excluding Medicare (commercial, Marketplace, Medicaid) for the following categories:
			• Gender
			• Racial or ethnic group:
			   • ~~Apply only to members with asthma.~~
			   • Report rates by race/ethnicity:
			   ▪ Asian, /Native Hawaiian or other Pacific Islander
			   ▪ Black or African American
			   ▪ Hispanic or Latino
			   ▪ White, not Hispanic or Latino
				Combine AHRQ measure numerator specifications for PQI #5, 11, 15. Exclude COPD codes from PQI #5.~~Refer to AHRQ measure specifications for numerator description.~~	HEDIS eligible population specifications for Asthma Medication Ratio. Use age range of 18 years and older.~~Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for asthma.~~	Administrative data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS

~~12~~	~~3.01~~	~~Asthma Admission Rate (PDI 14) – NQF # 0728~~	~~Apply only to members with asthma.~~ ~~Report rates by race/ethnicity:~~ • ~~Asian/Native Hawaiian or other Pacific Islander~~	~~Refer to AHRQ measure specifications for numerator description.~~	~~Refer to AHRQ measure specifications for denominator description. Use~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~

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

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
			• ~~Black or African American~~ • ~~Hispanic or Latino~~ • ~~White, not Hispanic or Latino~~ • ~~Unknown~~		~~HEDIS eligible population definition for asthma.~~				
~~13~~	~~3.01~~	~~Bacterial Pneumonia Admission Rate (PQI 11) – NQF # 0279~~	~~Apply only to members with asthma.~~ ~~Report rates by race/ethnicity:~~ • ~~Asian/Native Hawaiian or other Pacific Islander~~ • ~~Black or African American~~ • ~~Hispanic or Latino~~ • ~~White, not Hispanic or Latino~~ • ~~Unknown~~	~~Refer to AHRQ measure specifications for numerator description.~~	~~Refer to AHRQ measure specifications for denominator description. Use HEDIS eligible population definition for asthma.~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~
~~14~~	~~3.01~~	~~ED Visit Rate for Asthma~~	~~Report rates by race/ethnicity:~~ • ~~Asian/Native Hawaiian or other Pacific Islander~~ • ~~Black or African American~~ • ~~Hispanic or Latino~~ • ~~White, not Hispanic or Latino~~ • ~~Unknown~~	~~ED admissions for pulmonary diagnoses among members with asthma (use HEDIS eligible population for asthma)~~	~~Members with asthma (use HEDIS eligible population for asthma).~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~
~~15~~	~~3.01~~	~~ED Visit Rate for Depression~~	~~Report rates by race/ethnicity:~~ • ~~Asian/Native Hawaiian or other Pacific Islander~~ • ~~Black or African American~~ • ~~Hispanic or LatinoWhite, not Hispanic or Latino~~ • ~~Unknown~~	~~ED admissions among members with depression (use HEDIS eligible population for members with a diagnosis of major depression)~~	~~Members with a diagnosis of major depression (use HEDIS eligible population)~~	~~Administrative data~~	~~Annually~~	~~January 1 – December 31 of applicable measurement year~~	~~2017, 2018, and 2019 Application for Certification - QIS~~
1~~1~~6	4.01	Primary Care Physician Selection	Report members by product in the health plan's Covered California business with a personal care physician (PCP)	Number of Covered California members enrolled during the applicable Plan Year who have selected or were assigned to a PCP	Total Covered California membership enrolled during the applicable Plan Year	Administrative data	Quarterly	January 1 – December 31 (quarterly reporting periods to be defined upon request by Covered California)	2017, 2018, and 2019 Application for Certification - QIS / quarterly reports as requested
1~~2~~7	4.02	Primary Care Payment Strategies	Report the number and percentage of California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of California members enrolled during the applicable Plan Year	Total California membership enrolled during the applicable Plan Year	Administrative/ financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
				attributed to a provider with a payment reform strategy					
1~~8~~3	4.02	Primary Care Payment Strategies	Report the number and percentage of Covered California members attributed to providers for whom a payment strategy is deployed to adopt accessible, data-driven, team-based care with accountability for improving triple aim metrics	Number of Covered California members enrolled during the applicable Plan Year attributed to a provider with a payment reform strategy	Total Covered California membership enrolled during the applicable Plan Year	Administrative/ financial data	Annually	January 1 – December 31 of applicable measurement year	2018 and 2019 Application for Certification - QIS
1~~9~~4	4.03	Membership Attributed to IHMs	Report the number and percentage of California members in each product who are managed under an IHM	Number of California members enrolled during the applicable Plan Year managed under an IHM	Total California membership enrolled during the applicable Plan Year	Administrative/ financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
15~~20~~	4.03	Membership Attributed to IHMs	Report the number and percentage of Covered California members in each product who are managed under an IHM	Number of Covered California members enrolled during the applicable Plan Year managed under an IHM	Total Covered California membership enrolled during the applicable Plan Year	Administrative/ financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~21~~16	5.03	Hospitals reporting to CMQCC	Report hospital participation in CMQCC	Number of network hospitals reporting to CMQCC	Total number of hospitals providing maternity services in network	Network data/CMQCC participant list	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~22~~17	5.03	Hospitals meeting CalSIM goal for C-sections	Report hospital network performance for meeting CalSIM NTSV C-Section goal	Number of hospitals meeting CalSIM goal of NTSV C-Section rate at or below 23.9 percent	Total number of hospitals providing maternity services in network	Network data/clinical data submitted to CMQCC	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~23~~18	5.03	NTSV C-Section rate for each	For the plan's network of hospitals providing maternity services, report each hospital name,	Total number of NTSV C-Section	Total number of NTSV deliveries	Network data/clinical	Annually	January 1 – December 31	2017, 2018, and 2019

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
		network hospital	location, product network (HMO, PPO, EPO), and NTSV C-Section rate	deliveries		data submitted to CMQCC		of applicable measurement year	Application for Certification - QIS
~~24~~19	5.01	Payment strategies for maternity services	Report number of hospitals paid under each type of payment strategy for maternity services and the denominator (total number of network hospitals)	Number of hospitals paid under payment strategy or each payment strategy	Total number of network hospitals providing maternity services	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~25~~20	5.02	Opioid Adverse Events (Patients Treated with Naloxone)	Report rate for each network hospital:

Opioid-related ADE caused by medical error and/or adverse drug reactions

Rate Calculation: (Numerator / Denominator) x 100

Target-setting approach: six months historical data for baseline; 25th percentile figure from PfP Campaign (e.g., based on AHA/HRET Hospital Engagement Network data) | Number of inpatients treated with an opioid who received naloxone | Number of inpatients who received an opioid (top 5-10 prescribed) | Clinical data (medical record review, incident reporting systems, pharmacy reporting system) reported to CMS; HQI proposed | Annually | January 1 – December 31 of applicable measurement year | 2017, 2018, and 2019 Application for Certification - QIS |
| ~~26~~21 | 5.02 | CAUTI Rate for small-denominator hospitals | Report rate for ~~each~~ network hospitals below TBD denominator threshold:

CAUTI Rate – All Tracked Units - to evaluate improvement

Rate Calculation: (Numerator / Denominator) x 1,000

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 | January 1 – December 31 of applicable measurement year and prior measurement year | 2017, 2018, and 2019 Application for Certification - QIS |
| ~~27~~22 | 5.02 | CAUTI SIR for all hospitals excluding small-denominator hospitals | Report ~~rate~~ SIR for each network hospital excluding small-denominator hospitals:

CAUTI Standardized Infection Ration (SIR) – All Tracked Units – Relative performance

Rate Calculation: Numerator / Denominator

Target-Setting Approach: Twelve months historical data for baseline | Number of observed inpatient healthcare-associated CAUTIs for all tracked units | Number of predicted inpatient healthcare-associated CAUTIs for all tracked units (determined by NHSN) | NHSN or Partnership for Patients data reported to CMS | Annually | January 1 – December 31 of applicable measurement year | 2017, 2018, and 2019 Application for Certification - QIS |

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
~~28~~23	5.02	Urinary Catheter Utilization Ratio	Report rate for each network hospital: Urinary Catheter Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) x 100 Lower ratios are generally associated with better performance and may also impact the CAUTI rate	Number of inpatient indwelling urinary catheter days for all tracked units	Number of inpatient bed days for all tracked units	NHSN or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~29~~24	5.02	CLABSI Rate for small-denominator hospitals	Report rate for each network hospital below TBD denominator threshold: CLABSI Rate – All Tracked Units Rate Calculation: (Numerator / Denominator) x 1,000 Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient healthcare-associated CLABSIs for all tracked units	Number of inpatient central line days for all tracked units	NHSN, California Department of Public Health (CDPH), or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year and prior measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~30~~25	5.02	CLABSI SIR for all hospitals excluding small-denominator hospitals	Report ~~rate~~ SIR for each network hospital : excluding small-denominator hospitals: CLABSI SIR – All Tracked Units Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient CLABSIs for all tracked units	Number of expected inpatient CLABSIs for all tracked units (determined by NHSN)	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~31~~26	5.02	Central Line Utilization Ratio	Report rate for each network hospital: Central Line Utilization Ratio – All Tracked Units Rate Calculation: (Numerator / Denominator) x 100 Lower ratios are generally associated with better performance and may also impact the CLABSI rate	Number of inpatient central line days for all tracked units	Number of inpatient bed days for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~32~~27	5.02	C. Diff Rate for small-	Report rate for each network hospital below TBD denominator threshold:	Number of inpatient	Number of inpatient bed	NHSN, CDPH, or Partnership	Annually	January 1 – December 31	2017, 2018, and 2019

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
		denominator hospitals	Lab-Identified C. Diff Rate Rate Calculation: (Numerator / Denominator) × 1,000 Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	hospital-onset C. diff lab identified events for all tracked units	days for all tracked units	for Patients data reported to CMS		of applicable measurement year _and prior measurement year_	Application for Certification - QIS
~~33~~2~~8~~	5.02	C. Diff SIR _for all hospitals excluding small-denominator hospitals_	Report ~~rate~~ _SIR_ for each network hospital _excluding small-denominator hospitals_: Lab-Identified C. Diff SIR Rate Calculation: Numerator / Denominator Target Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed inpatient hospital-onset C. diff lab identified events for all tracked units	Number of expected inpatient hospital-onset cases of C. diff for all tracked units	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~34~~2~~9~~	5.02	SSI-Colon Rate _for small-denominator hospitals_	Report rate for each network hospital _below TBD denominator threshold_: Colon Surgery SSI Rate Rate Calculation: (Numerator / Denominator) × 100 Target-Setting Approach: Twelve or twenty-four months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of SSIs related to colon surgeries (based on NHSN definition)	Inpatients having the colon procedures included in the NHSN operative procedure category	NHSN, CDPH, or Partnership for Patients data reported to CMS	Annually	January 1 – December 31 of applicable measurement year _and prior measurement year_	2017, 2018, and 2019 Application for Certification - QIS
~~35~~3~~0~~	5.02	SSI-Colon SIR _for all hospitals excluding small-denominator hospitals_	Report ~~rate~~ _SIR_ for each network hospital _excluding small-denominator hospitals:_: Colon Surgery SSI SIR Rate Calculation: Numerator / Denominator Target-Setting Approach: Twelve months historical data for baseline (various possible data sources: NHSN, 2013 CHART, 2014 CDPH)	Number of observed 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	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
3~~16~~	5.01	Hospital Reimbursement at Risk for Quality Performance	Report the percentage of hospital performance at risk for quality performance (metrics may include but are not limited to HACs, readmissions, patient satisfaction, etc.)	Hospital payment dollars tied to quality performance	Total hospital payment dollars	Financial data	Annually	January 1 – December 31 of applicable measurement	2017, 2018, and 2019 Application for Certification -

Metric No.	2017 Contract Section	Measure Name	Description	Numerator	Denominator	Data Source	Reporting Frequency	~~Reporting~~ Measurement Period	Reporting Method
								year	QIS
~~37~~32	5.01	Hospitals with Reimbursement at Risk for Quality Performance	Report the number and percentage of hospitals with reimbursement at risk for quality performance (metrics may include but are not limited to HACs, readmission, patient satisfaction, etc.)	Hospitals with payment tied to quality performance	Total number of network hospitals	Network data/financial data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - QIS
~~38~~33	6.01	Members Using Wellness Benefit	Report the number and percentage of members who have a preventive care visit ($0 member cost share)	Members incurring at least one preventive care visit/service	Total membership across all lines of membership excluding Medicare	Claim/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification
~~39~~34	6.01	Members identified as obese who are participating in a weight management program	Report the number of obese members who are participating in weight management programs	Number of California members identified as obese who are participating in weight management program	California members identified as obese	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI
~~40~~35	6.01	Members identified as tobacco dependent who are participating in a smoking cessation program	Report the number of tobacco-dependent members who are participating in smoking cessation programs	California members identified as tobacco dependent participating in smoking cessation program	California members identified as tobacco dependent	Claims/ encounter data	Annually	January 1 – December 31 of applicable measurement year	2017, 2018, and 2019 Application for Certification - Covered California eValue8 RFI