Summary of DPH Responses on Plan Data Sharing

	Enrollment Data Freq.		Other Data		File Format/Sharing		DPH Contact Points with Plans	
	Current	Ideal	Current	Ideal	Current	Ideal	Current	Ideal
Alameda	monthly	monthly	pharmacy	enrollment & unenrollment dates; ABC: Flag new members	text file uploaded to Data Warehouse	current	Business Intelligence	Plan provides a primary & back up contact to address technical issues
Arrowhead	monthly	monthly	assignment gaps, lab data	pharmacy – still working on	CSV	current	multiple depts = double work & inconsistencies in data	One team to handle data to & from Plan
Contra Costa	nightly		claims, encounter, pharmac, referral	NA	shared Data Warehouse	current	NA, shared Data Warehouse	
Kern	monthly		gaps in care,claims	unenrollment dates	download/search from Plan Provider Portal; not in actionable format	in progress: direct feed into EDW&Analytic tool	not defined	
Los Angeles	monthly		out of network claims, encounters, retail post-adj pharmacy claims in CALINX format; cap & retro-cap payment	restrosepctive enrollment	Electronic; specified format for each transasction type downloaded from FTP site; encrypted with PGP		Systems Op Manager in Managed Care Services	
Natividad	monthly			enrollment date, term date,	Excel from portal	current	CCAH responsive to requests on access to portal for add'l staff	Current
Rivserside	monthly	monthly	member roster,eligibility, authorizations, claims, RX claims, & lab results		Excel from secure FTP site			
Santa Clara	monthly	monthly	enrollment data	in progress: vendor app to map records	Files from FTP	bidirectional interface	1 contact from our Panel Mgment + 1 from EHR Team	

DPHs can access the full responses to all of the Plan Data Sharing questions on the SNI Link: https://safetynetinstitute.org/member-portal/programs/quality-incentive-program/ v. 4/18/2018

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	Enrollment Data Freq.		Other Data		File Format/Sharing		DPH Contact Points with Plans	
	Current	Ideal	Current	Ideal	Current	Ideal	Current	Ideal
San Francisco	2/month; monthly	2/month; monthly	SFHP: claims, encountner & pharmacy data	SFHP: lab, gaps in care; ABC: utilization	SFHP: Text file; ABC: download from portal – cumbersome	SFHP: current; ABC: text files via secure FTP server	Matrix Analytics Data Integration (Dept) under IT	SFHP: current ABC: work directly with staff creating & transmitting files
San Joaquin	monthly	monthly	capitation, enrollment data	care gaps reports, pharmacy data, claims data from HealthNet Hill Physician; CIN from HPSJ	Hill Physician: Text file via email; HPSJ: download PCP assignmentse from portal	text file	Clinical IT Department is responsible for interacting with the Plan and receiving data	
San Mateo	monthly	monthly	eligibility, providers, claims, pharmacy claims, authorizations	current; future plans to run Health Plan data through our EMPI	Current		Business Intelligence Dept. has sole responsibility for managing Health Plan data.	HPSM: current; next challenge: improve data-sharing w/ SM County Human Service Agency
UCD								
UCI	monthly	monthly	enrollment, gaps in care, ER utilization, ER readmit rates, capitation	enrollment date, unenrollment date.	mostly Excel; some paper & pdf	Excel	11 individuals from a few different groups	2 main contacts to receive&disseminate data to appropriate people
UCLA		monthly	eligibility, varied aggregated quality and utilization data	unenrollment data, current vs. historical member ID	manual download excel from portal	automatic delivery via SFTP	multiple departments receive health plan data	central SFTP accessible by a few depts.
UCSD	monthly	monthly	enrollment date; capitation file	enrollment date, unenrollment date; SSN	download from portal	direct FTP	Health Information Management	current
UCSF	monthly	monthly	enrollment data (except Anthem); CALINX pharmacy data	unenrollment date; EDW to match & store CALINX data	password protected text file via SFTP	flat text file via SFTP with no encryption	Enterprise Data Warehouse	IT/technical person + someone with programmatic/ clinical knowledge
Ventura	monthly	monthly	capitation, assignment		SFTP		Population Health & Ambulatory Admin	

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DPH Raw Responses Regarding Plan Data Sharing – A. Access to Assignment Data

	A1. Currently, what data elements do you receive from the Plans?	A2. Which data elements are missing that prohibit you from mapping to your systems' records?	A3. Currently, how frequently are you able to receive or access this information? What frequency would be ideal for QIP?	A4. Currently, what is the format that you receive the information? Please specify by types of data Ideal?	A5. Which person or department is responsible for interacting with or receiving the Plan data? If multiple, please describe.
Alamada (AA)	Enrollment: monthly Pharmacy Data: monthly	Calculation to find newly enrolled and un-enrolled patients completed by AHS BI team	Receiving monthly for both enrollment and pharmacy. monthly is sufficient	Text file which is then uploaded into the data warehouse. Text file is what we need.	Business Intelligence Department. The plans should provide a primary point of contact and a back-up person that can address technical issues
Alameda (ABC)	Enrollment: monthly Pharmacy Data: monthly	New members are flagged Calculation to find newly enrolled and un-enrolled patients completed by AHS BI team	Receiving monthly for both enrollment and pharmacy. monthly is sufficient	Text file which is then uploaded into the data warehouse. Text file is what we need.	Business Intelligence Department. The plans should provide a primary point of contact and a back-up person that can address technical issues
Arrowhead	Enrollment dates, provider assingments gaps in care, claims/encounter, pharmacy data (work in progress), lab data.	We are still working on pharmacy data	We get this data monthly. Ideal: monthly.	Currently receive csv file. Ideally, csv file.	We currently have multiple departments that handle information from the plan, we have a team that handles vaccine and lab information transfers, another one that deals with claims and yet a third one that handles enrollment data. There should be one team of people that handles all of the data that goes and come from the plan, to reduce double work and inconsistencies that we have seen in the data.
Contra Costa	Shared data warehouse includes enrollment, claim, encounter, pharmacy data, referrral data, etc.	NA	Shared Datawarehouse has the information nightly	NA, Shared Datawarehouse	NA, Shared Datawarehouse
Kern	Currently receiving enrollment dates, gaps in care and claims data. The data is provided through plan portals, and not necessarily in a highly actionable format. We are in the process of establishing a regular feed into a new EDW from both MCMC plans providing this information in a much more actionable format.	Unenrollment Dates	It's currently available on a monthly basis, provided through the plans provider portal	Currently available for download or searching through Plan Provider portal. Direct feed into EDW and Analytics tool would be ideal.	Currently not clearly defined.

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Los Angeles (LACHP)	We receive the standard data elements within the following transaction sets: -X12 834 Enrollment, -Multi-record, comma-separated text file based on the X12 837I/P Out of Network claims/encounters, -Retail Post Adjudicated Pharmacy claims in Calinx Rx format and -Proprietary flat file for Capitation and retro- capitation payment information.	We do not receive retrospective enrollment records on the X12 834 enrollment transaction which would allow us to update our enrollment records to reflect the retrospective enrollment changes made.	We receive monthly (full beginning of month) and daily (incremental) X12 834 Enrollment files, and monthly OON claims/encounters, and monthly retail Post Adjudicated pharmacy claims, and monthly Capitation and retrocapitation payment information.	All information is received in electronic format, in the specified format for each transaction type identified above, and is downloaded from the Health Plan's Secure FTP site.	Uriel Acuña, Systems Operation Manager, Managed Care Services.
Los Angeles (HNHP)	We receive the standard data elements within the following transaction sets: -X12 834 Enrollment, -Flat file, comma-separated text file for Out of Network claims/encounters (one for Professional and another for Institutional), -Retail NCPDP Post Adjudicated claims, which is being transitioned to Calinx Rx format -Proprietary flat file for Capitation and retro-capitation payment information.	We do not receive retrospective enrollment records on the X12 834 enrollment transaction which would allow us to update our enrollment records to reflect the retrospective enrollment changes made.	We receive monthly (full beginning of month) and daily (incremental) X12 834 Enrollment files, and monthly OON claims/encounters, and monthly retail Post Adjudicated pharmacy claims, and monthly Capitation and retrocapitation payment information.	All information is received in electronic format, in the specified format for each transaction type identified above, and is downloaded from the Health Plan's FTP site, with the files encrypted with PGP (Pretty Good Privacy) and via the Provider Portal.	Uriel Acuña, Systems Operation Manager, Managed Care Services.
Natividad (CCAH)	Member Number, Last Name, First Name, DOB, Gender, Co-Pay Address, City, State, Zip, Home Phone, Eff Date, Exp Date, Aid Code, County Code SPD, CCS. The first 5 elements (Member #, Name, DOB and Gender) is all we use to patient match.	Enrolled Date and Term Date would be more efficient, however since we have the process built, the current process works fine.	CCAH finishes the enrollee list by the 10th of every month. At that point I log on and download the patient list for the current month.	We download an Excel file. This is the preferred file format.	Our current process seems to be working. CCAH has been responsive when we have requested access to the portal for additional NMC staff.

DPH Raw Responses Regarding Plan Data Sharing – A. Access to Assignment Data

	A1. Currently, what data elements do you receive from the Plans?	A2. Which data elements are missing that prohibit you from mapping to your systems' records?	A3. Currently, how frequently are you able to receive or access this information? What frequency would be ideal for QIP?	A4. Currently, what is the format that you receive the information? Please specify by types of data Ideal?	A5. Which person or department is responsible for interacting with or receiving the Plan data? If multiple, please describe.
Santa Clara	We have different data files depending on payor. We could provide a redacted example, if necessary. Data elements from one of our eligibility files: Eligibility File Data Elements:, Subscriber_ID, Epic_MRN, LastName, FirstName, MiddleName, Gender, SSN, DOB, AGE, Addr1, Addr2, City, State, Zip, Phone, Mobile_Phone, Email, Language_Spoken, Ethnicity, GROUP, RateCode, Enroll_EffDate, Enroll_TermDate, Enroll_Change_Date, Payto_Fullname, PCP_Fullname, PCP_NPI, PCP_Effdate, PCP_TermDate, PCP_Change_Date, Record_Status,	We are waiting to set up additional applicationsf rom our vendor to map into our own records. Currently we use a database or data warehouse to manage different kinds of plan data.	We received the Data monthly. This makes sense based on the monthly eligibility of the patients, so it would be ideal to keep it monthly.	We access files through a secure FTP, which works fine. Ideally, we'd have a bidirectional interface, but it is doubtful that this is realistic (especially for commercial payors like Blue Cross).	We have one point of contact from our Panel Management group and one point of contact from our EHR team.
San Francisco (SFHP)	We receive membership files twice a month which include member names, member identifiers used by SFHP and by Medi-Cal, enrollment dates, address, PCC assignment, member demographics (gender, language, ethnicity). We receive monthly claims/encounters and pharmacy data. No lab data. We don't receive any information on gaps in care from SFHP.	None	See A1. The current frequency is fine.	All data files from SFHP are electronic text files. The current format is fine.	The Matrix Analytics Data Integration (MADI) department receives the data. MADI is part of Information Technology. The current process is fine.
San Francisco (ABC)	We receive membership files once a month which include member names, member identifiers used by SFHP and by Medi-Cal, enrollment dates, address, PCC assignment, member demographics (gender, language, ethnicity). No utilization data is provided by Anthem.	None from membership files. We receive no utilization data so this is missing.	See A1 for membership. We receive no utilization data from Anthem Blue Cross and would need this monthly for QIP. We have tried repeatedly to get utilization data over the years. The current membership file frequency is fine.	We must download monthly membership files from a provider portal. No utilization data. The current process is very cumbersome and can't be automated. We have requested electronic text files via a Secure FTP server but Anthem wouldn't provide the membership files this way.	The Matrix Analytics Data Integration (MADI) department receives the data. MADI is part of Information Technology. The current process process is quite time-consuming. We are not able to work directly with the staff creating the files and transmitting them. Anthem seems to have a cumbersome process for

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	A1. Currently, what data elements do you receive from the Plans?	A2. Which data elements are missing that prohibit you from mapping to your systems' records?	A3. Currently, how frequently are you able to receive or access this information? What frequency would be ideal for QIP?	A4. Currently, what is the format that you receive the information? Please specify by types of data Ideal?	A5. Which person or department is responsible for interacting with or receiving the Plan data? If multiple, please describe.
					considering and approving data sharing. We have tried repeatedly to get utilization data over the years.
San Joaquin	We receive capitation data from Health Plan of San Joaquin which includes enrollment date, PCP assignment date, and rate plan. We also receive claims encounter separately from the captitation data with the following fields: date of service, procedure codes, diagnosis codes, language, ethinicity, claim status, and place of service. We have received care gaps reports in the past but the Health Plan of San Joaquin changed system and is having issue generating the care gap reports. We do not receive pharmacy data. HealthNet has a delegated agreement with Hill Physician. Does other health system have a similar setup? We're able to get assignment information but it's a challenge in obtaining claims data.	The Medi-Cal population with HealthNet is delegated to Hill Physician. We received member data including CIN number which is used for mapping individuals to our EHR. The Health Plan of San Joaquin does not provide the CIN number and only provides their local claims system member ID. We add the member ID into our system so we could map the individual.	We are receiving data on a monthly basis. For PCP assignments, we can download the report on a ad-hoc basis from Health Plan of San Joaquin. Hill Physicians send us an assignment file monthly. monthly download may suffice for now.	We receive the format in a pipe delimited text file from Hill Physician via secure email. The PCP assignment file from Health Plan of San Joaquin can be downloaded from their provider portal. Pipe delimited format should be good enough.	The clinical informatics department with assistance from IT is responsible for interacting with the plan and also receiving the plan data.
San Mateo (HPSM)	We receive eligibility, providers, medical claims, pharmacy claims, authorizations from one health plan—the Health Plan of San Mateo (HPSM).	Our data elements and patient identification are good; however we are planning in the near future to run our Health Plan data through our enterprise master patient index (EMPI) to better match Health Plan members with our patients.	We receive monthly updates of the data in question A1 from HPSM.	Unless QIP wants submissions more frequently than the quarter, monthly at the minimum would be ideal. In that way we can monitor progress before official quarterly, semi-annual, or annual submissions.	The Health System Business Intelligence Department (BI) has sole responsibility in managing, interacting with, and extracting Health Plan data. San Mateo Medical Center requests data and reports from BI, and will do so for QiP. [No further recommendations for Plan interaction]. We have made substantial progress in data sharing with our Health Plan over the past two and a half years. The next challenge for us is to improve

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					data sharing with the San Mateo County Human Service Agency (HSA)—the agency that ultimately determines Medi-Cal eligibility for county residents. Some times there are demographic mismatches (names in particular) that are difficult for SMMC and HPSM to reconcile with HSA.
UCD	Note: "UCD is only just now beginning to receive assignment of Medi-Cal lives so we have no direct experience with how Medi-Cal Managed Care Plans are providing data or what data is provided. Also, as a GMC county, our experience with the health plans is likely not similar to many of the other public hospitals who are not always dealing with commercial health plans with significant experience in commercial HMOs. We've provided some observations related to Access to Assignment Data and what makes for successful and productive interaction with health plans in a capitated arrangement"				
	monthly (or more frequent) enrollment files are critical to success. Enrollment files must contain adequate information to allow each individual patient to be mapped to an existing record, if one exists. Health Plans generally do not carry a health system's member record number in their system, so demographic information to identify the patient is needed for new enrollments. • Lab and pharmacy fill data can be helpful, if it can be uploaded into the EMR as discreet data elements. Access to behavioral health prescriptions is important, but very rarely made available. Our pharmacist has been able to gain access to patient medication records (costs, number of fills, etc) through CalLinx and has found that to be very helpful, though we don't presently put that into the EMR.		Data latency is the most significant challenge for areas such as gaps in care, claims/encounter, etc. Chasing metrics requires frequent data updates to identify which patients are in need of which type of test/visit/documentation. monthly updates that show by patient who is in the numberator and denominator are needed, if more real time updates are not available. A big challenge is that health plans run off claims and are always 2 to 3 months behind, so a report generated in November will show results through maybe September (sometimes earlier). Similarly, by mid-year, a health plan is only likely to be able to give you information about the first quarter of performance. This makes it extremely challenging for a provider to know which patients to target and can result in a lot of manual report chasing. The best	We receive files in Excel and tab delimited formats and find these to be useful and usable most of the time. These formats allow us to import the data into the EMR or other analytic tools where it can be manipulated. Plans have given us paper lists of high utilizer patients or patients in case management, and these lists are generally of no use as they require manual review. Some plans make patient information available through a portal (such as external visits/lab data), but this rarely has an effective interface to an EMR so it can be more time-consuming than is worthwhile to try to use the health plan patient portal as a source for patient management. Of course, the most important consideration in how to receive data and who should receive it is ensuring that all data transfers are HIPAA compliant. Electronic,	We find that it is best to have more than one person in IT as well as the business owner of the data notified when an SFTP has been initiated by a health plan and then identify a single point person in IT who is responsible for pulling the files off the SFTP.

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<tr><td></td><td></td><td></td><td>option is for providers is to track these metrics in their EHR (if they have one) or use a 3rd party vendor to calculate the quality results on a more realtime basis based on data from the EMR.</td><td>secure files transfers through an SFTP or through an encrypted email channel are best.</td><td></td></tr>
<tr><td>UCI</td><td colspan="5">
<table>
<tr><td></td><td colspan="2">Enrollment Files</td><td colspan="2">Capitation Reports</td><td colspan="2">Care Gap Files</td><td colspan="2">Annual Wellness Visits</td><td colspan="2">ER Utilization Report</td></tr>
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<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="9">Enrollment data and claims can be pulled from the individual portals for each network above as needed.</td><td></td><td></td></tr>
<tr><td colspan="7">*We just started receiving some of this data from the networks.</td><td></td><td></td><td></td><td></td></tr>
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Consistency across all plans on what data is shared, the format and the frequency.
</td></tr>
<tr><td>UCI</td><td>Enrollment data, gaps in care, ER utilization, readmit rates
***Need to see if billing receives Claims/Encounter data; they do get capitation files.</td><td>CalOptima CCN files do not have enrollment and unenrollment dates. This is a fee-for-service plan.</td><td>monthly Excel files would be ideal for sorting and disseminating data.</td><td>monthly Excel files would be ideal for sorting and disseminating data.</td><td>FQHC Administration – Jennifer Mosher, Patricia Ramirez, Ivan Coziahr and Diana Crook; Ambulatory Administration – Tami Wiley; Practice Managers – Mary Ezzat and Aaron Nisley; Billing – Mindy Vuong, Rhoda Peng and Gina Carroll; Executive Director of Operations – Natalie Maton
Two main points of contact to receive and disseminate data would be ideal so pertinent information can get to the appropriate people.</td></tr>
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UCLA	UCLA has access to manually download Managed MediCal eligibility files. UCLA receives varied aggregated quality and utilization data for some Managed MediCal products. Specific fields include: Member ID; Name; Gender; DOB; HP Code; HP From; OPT From; PCP From; Assigned PCP; Phone Number; Address	Indicator if patient came in/out of Managed MediCal, and if so, if the Member ID is the same or is different from the historical Member ID. Commercial PPO ACOs are sending 2 fields (Current Member ID & Historical Member ID) if the patient is assigned a new one upon re-enrollment with the plan HP From: Similarly to Member ID, we would need a way to know if the member moved in/out of the health plan to accurately track enrollment periods. Otherwise, the enrollment may look underreported if we rely on the patient's most recent enrollment start date.	Ideally, monthly.	Excel is the current format, reliant on a manual download process from a secure online portal. It would be ideal if the plans could automatically send the data vs us having to request or run it manuallyIdeally, an SFTP would be set up with each plan to ensure automatic delivery of data vs. a manual download process.	Currently, there are multiple stakeholders at UCLA involved in receiving the health plan data. For example, the Dept. of Family Medicine is the current recipient of eligibility files and aggregate performance data, but this will not be the team reporting for the health system on QIP. The Office of Health Informatics & Analytics (OHIA) and the Office of Population Health and Accountable Care (OPHAC) would need regular access to this data. The ideal point of contact process would be development of a central portal (SFTP) where Family Medicine, OHIA, & OPHAC would have central access to patient-level and aggregate-level reporting.
UCSD (CHG)	Patient enrollment was verified by files received from Molina and CHG on a monthly basis with the following criteria: enrollment during and in the last month of the PRIME measurement period without a gap in coverage of 45 days (rounded to 30 days) or more. Enrollment dates: capitation file – eligibility for month of file	CHG does not provide the patient SSN. Without the SSN identifier the matching rate is lower. No enrollment dates, unenrollment dates	Receive monthly. monthly is fine.	Downloadable from plan's portal Ideal – Direct ftp transfer from their site	IS Data Analyst (without SSN, need to run patient matching algorithm)
UCSD (Molina)	Same as above. Enrollment dates: date in received file.	From the monthly lists received from Molina, about 97.3% of the patients are either matched in our system, or a brand new patient record is created.	Receive monthly. monthly is fine.	Downloadable from plan's portal Ideal – Direct ftp transfer from their site	Health Information Management Ideal: Health Information Management

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UCSF	UCSF receives enrollment data on a monthly basis from SFHP but not from Anthem (though Anthem makes up a smaller population). In addition, UCSF worked with SFHP to initiate a transfer of monthly CALINX pharmacy data but there have been some gaps in the data transfer process (missing months) and we do not yet have a data warehousing system to accurately accept/store the data, match it to UCSF patient data, and have not yet been able to incorporate it into clinical interventions.	From SFHP, we receive all necessary enrollment data to map members to our patient records. Termination/unenrollment dates are not provided in the file. Other Note: When looking at HEDIS quality metrics produced by the plans, performance is typically lower and less meainingful (for UCSF at leasts) when using plan/claims data as compared to metrics captured with data directly from the EHR. Strong preference is to make health plan data optional for QIP(with exception of enrollment data). Claims data is powerful for giving visibility into total cost of care and utilization trends needed for understanding overall performance under value-based care. However, claims data is less valuable (and more burdensome for IT/technical teams with limited value-add) for quality improvement measurement at systems with an integrated EHR across all settings.	We receive SFHP enrollment data monthly	SFHP sends an encrypted password protected text file to UCSF via Secure File Transfer Protocol. Password encryption makes it a bit clunky to use for data warehousing purposes; since we are using SFTP, the preference would be a flat text file with no zip/encryption.	UCSF Enterprise Data Warehouse manages secure file transfer data transfers with external entities. However, they are still building expertise around payor data, claims data, and member identity management (mapping to UCSF). There is a learning curve here, so I'd recommend that interactions between the DPH and health plan include both an IT/technical person as well as someone with knowledge of the programmatic/clinical needs (e.g.: Population Health Analytics manager/leader or PRIME leader).
Ventura	Capitation data and monthly assigned lives data	We can map to our system's records, though it is not a perfected method.	We receive both of these data elements monthly.	SFTP	Population Health and ambulatory admin retrieve the data from an SFTP site.

DPH Raw Responses Regarding Plan Data Sharing – B. ACCURACY OF ASSIGNMENT DATA

	B1. Do you currently track or at least are feasibly able to ascertain the % with inaccurate demographics (e.g. letters returned as incorrect address, wrong or disconnected phone #)?	B2. Do you currently track or at least are feasibly able to ascertain the % unable to contact/unable to verify contact (e.g. no response to letters, messages left on voicemail)?	B3. What % of assigned individuals are incorrectly assigned?	B4.What is the % of assigned indivdiuals who are duplicated on assignment lists?
AHS	Not currently tracking and is not used in our analysis. The only thing we're currently using is the Medical Home assignment	Not currently tracking.	Not currently tracking incorrect assignments.	We do not track this at this time and don't have the ability to identify these patients.
ARMC	An example from the last audit: ~ 20% data was off; we had to match the data and send it back to the Plan. The data that is not matching is the lab results, or ICD10. Specifically on demographics name ssn and others is very good, but address and phone numbers are different about 30%-40% of the time, because our patients move often and they also get subsidize phone numbers.	[no response]	[no response]	The plan does not have a unique way to handle all of the data that we are sending as well as receiving so we spend a lot of time making sure that their data is correct (which most of the times is either behind or incorrect) and also due to the multiple department that they request data from there is a lot of effort duplication.
CCRMC	We run the membership address data against USPS database monthly and update the addresses if the member has moved or blank the address if it is not accurate.		Assignment process developed by IT and a shared list is in the datawarehouse	NA
KMC	YES. 3981/28315 with no or a placeholder for a phone number of those 330 have DHS or homeless shelter as their address. We don't currently track non-responsiveness or inaccurate phone numbers	YES. 3981/28315 with no or a placeholder for a phone number of those 330 have DHS or homeless shelter as their address. We don't currently track non-responsiveness.	No	No
LA (LACHP)	We are feasibly able to track this as the key demographic data elements are stored in historical fields (i.e., the history of edits are tracked)	We are feasibly able to ascertain the % unable to contact/unable to verify contact.	The health plan would be better able to answer this question, as they would be contacted by the member to disenroll.	We do receive some duplicated assigned individuals, however, they are identified under unique identifiers attributed to the State, therefore, we do not consider them as true duplicates.
LA (HNHP)	We are feasibly able to track this as the key demographic data elements are stored in historical fields (i.e., the history of edits are tracked)	We are feasibly able to ascertain the % unable to contact/unable to verify contact.	The health plan would be better able to answer this question, as they would be contacted by the member to disenroll.	We do receive some duplicated assigned individuals, however, they are identified under unique identifiers attributed to the State, therefore, we do not consider them as true duplicates.
NMC (CCAH)	No	No	No	NMC gets monthly assignment reports unduplicated. At least for PRIME, NMC uses a SQL server Reporting Services tool to aggregate data for the PRIME Eligible Population. SSRS used for only for PRIME.

DPH Raw Responses Regarding Plan Data Sharing – B. ACCURACY OF ASSIGNMENT DATA

<table>
<tr><th></th><th>B1. Do you currently track or at least are feasibly able to ascertain the % with inaccurate demographics (e.g. letters returned as incorrect address, wrong or disconnected phone #)?</th><th>B2. Do you currently track or at least are feasibly able to ascertain the % unable to contact/unable to verify contact (e.g. no response to letters, messages left on voicemail)?</th><th>B3. What % of assigned individuals are incorrectly assigned?</th><th>B4.What is the % of assigned indivdiuals who are duplicated on assignment lists?</th></tr>
<tr><td>SCVMC</td><td>Approx. 14% of return mail
Recent totals 737 sent and 101 returned. This was from the January eligibility file, 1 month of data

Coverage Issues (patients has lost coverage by the time of outreach or switched providers): 214/214</td><td>NO. We tried a outreach back in January and the results are as follow in chart below (don't anticipate continuing, low ROI and would require staffing).
<table><tr><th></th><th>Appt Made</th><th># of Patient</th><th>Grand Total</th></tr><tr><td>Coverage Issues (patients has lost coverage by the time of outreach or switched providers)</td><td></td><td>214</td><td>214</td></tr><tr><td>Phone # (Wrong phone numbers)</td><td></td><td>80</td><td>80</td></tr><tr><td>Outreached (3 attempts were made to reach by phone)</td><td>5</td><td>439</td><td>444</td></tr><tr><td>Grand Total</td><td>5</td><td>733</td><td>738</td></tr></table></td><td>No data. After some outreach, some patinets were assigned ot the wrong provider after they didn't. Also, very rarely, patients are assigned via auto-assignment to closed providers or wrong specialty (e.g., peds for adults).</td><td>We have never seen this, but it is possible. If we need to put a percent, either 0% or less than 1% would be fine.</td></tr>
<tr><td>SF (SFHP)</td><td>[Answers provided by SFHP directly.]
We track returned mail and are reporting 19,524/ 53,697 or 36% of SFHN members we have inaccurate demographics on.</td><td>We track when we are able to correct the address in our system per member communication and are reporting 12,631 / 53,697 or 24% are unable to verify correct demographics</td><td>Members have the opportunity to choose a PCP when enrolling with Medi-Cal via the Health Care Options form. When they do not make a choice, we assign them to a PCP based on several factors (i.e. prior medical history, language, neighborhood etc.) Members can call and change their PCP at any time. We don't track the percentage of members who say that they DID make a choice and we assigned them elsewhere.</td><td>Members have the opportunity to choose a PCP when enrolling with Medi-Cal via the Health Care Options form. When they do not make a choice, we assign them to a PCP based on several factors (i.e. prior medical history, language, neighborhood etc.) Members can call and change their PCP at any time. We don't track the percentage of members who say that they DID make a choice and we assigned them elsewhere.</td></tr>
<tr><td>SJGH</td><td>This is difficult to ascertain unless we outreach to the assigned individuals.</td><td>This is difficult to ascertain unless we outreach to the assigned individuals.</td><td>I'm not sure what this means.</td><td>There are currently no duplications.</td></tr>
</table>

DPH Raw Responses Regarding Plan Data Sharing – B. ACCURACY OF ASSIGNMENT DATA

	B1. Do you currently track or at least are feasibly able to ascertain the % with inaccurate demographics (e.g. letters returned as incorrect address, wrong or disconnected phone #)?	B2. Do you currently track or at least are feasibly able to ascertain the % unable to contact/unable to verify contact (e.g. no response to letters, messages left on voicemail)?	B3. What % of assigned individuals are incorrectly assigned?	B4.What is the % of assigned indivdiuals who are duplicated on assignment lists?
SMMC	As part of Prime, we systematically record and track race, ethnicity, and language (REAL) data accuracy and have begun to ask SOGI (sexual orientation and gender identity) of all patients. As of January 2018, currenly 91.4% of our patients have accurate REAL data recorded. For REAL (35,385/38,739 patients)	We don't currently systematically track this enterprise wide, but the capability exists.	We don't currently systematically track this enterprise wide, but the capability exists.	We don't currently systematically track this enterprise wide, but the capability exists.
UCI	No.	No.	CalOptima CCN 100%; Monarch approx.. 3%; Noble Mid approx..7%.	Monarch – 0% Noble Mid – 0%
UCLA	Yes. No technical resources are available to run this data at this time.	Technically do-able, but no standard process to do bulk outreach to test contact info other than tied into day-to-day care processes (e.g. setting up an appointment). No technical resources are available to run this data at this time.	No.	No technical resources are available to run this data at this time.
UCSD	In March 2017, an outreach pilot program was conducted, using Cipher Health to generate automated calls to patients. These are the statistics from the pilot: • Start Date: March 6th 2017; Target Audience: Molina Patients (1716pts) o 13,046 assigned to UCSD; 7316 assigned to a PCP at UCSD; 4003 not assigned to a PCP + not seen at UCSD • 1716 of Molina population not assigned to PCP but have been seen at UCSD: o 250 Seen at UCSDH over the past year; 1466 Some contact at UCSDH • Call Data (started on Mar 6th): 60 calls / day; Mon – Thur (9a, 11a, 5p, 7p), Fri (9a, 11a) o Unsuccessful calls – Text and/or Voice Mail after 2 attempts o 1635 Pts called: 45% (738) reached, 30% (220) requiring intervention, median time to intervene = 9 hrs, 71% (156) interventions with details recorded • Follow up phone calls: 36% Not UCSD; 22% Appt; 29% VM/ No Answer; 9% No Concerns; 4% Misc • No data on wrong numbers, and do not have data on wrong addresses		No duplicate information on list sent to Cipher Health	
UCSF	Unable to ascertain.	Unable to ascertain.	Unable to ascertain.	Unable to ascertain.
VCMC	Each of our clinics keeps track of this information for themselves. We do not aggregate all assigned lives on a regular basis. This is something we have started talking about and are looking to do.	Each of our clinics keeps track of this information for themselves. We do not aggregate all assigned lives on a regular basis.	We do not currently track on a regular basis.	We do not currently track on a regular basis.

DPH Raw Responses Regarding Plan Data Sharing – C. ASSIGNED NOT YET SEEN

	C1. Do you currently track or at least are feasibly able to ascertain for this data request % Assigned Not Yet Seen?	C2. Do you currently track or at least are feasibly able to ascertain for this data request % Assigned Not Yet Seen stratified by age (e.g. by HEDIS age groups):	• C3. Do you have a standard number of outreach attempts made by your system to individuals who are assigned but not yet seen?
AHS	We can but don't have this report available yet.		
ARMC	Not by age group		
KMC		No	No
LA (LACHP, HNHP)	We haven't done the stratification yet.	There isn't a standard number of outreach attempts. Those are done by the individual PCMHs and it's up to them to decide how persistent they wan to be.	
NMC (CCAH)	YES. ONLY For CCAH patients, the list of new patients assigned to practice is pulled and scheduled a visit. It is possible to track assigned but not yet seen. We do not calculate the actual rates.	YES. ONLY For CCAH patients, using the same report for assigned but not seen, the age of the patients can be obtained and stratified if needed. Report will have to be created to do this. We do not calculate the actual rates.	Yes for Monterey County Health Department. Waiting to hear back from Irma/NMG. Average is 3 attempts to reach out and reschedule. But depending on case and severity, more attempts are made including certified letters.
SCMVC	We cannot easily do this.	We send a welcome letter to patient with MRN. Average # of attempts by Peneling department is 1 letter sent to patient.	
SFHN	SFHP: See answers in above in B. ABC: not able to address		
SJGH	No. Based on our December capitation file for one of our health plan partner, we have a 84% rate of the population that was seen or appeared in the HER. 35043/41716	No	I'm not sure what the number of outreach attempts is currently. However, we plan on creating a strategy in the future for the assigned but not seen population.
SMMC	CareAdvantage (Medicare Managed Care duals): 165/2143 = 8% never seen at SMMC Medi-Cal (not CareAdvantage; may include duals with FFS Medicare): 11035/35822 = 31% never seen at SMMC	We don't currently track but the capability exists.	Three times.
UCI	No. We were able to calculate the Assigned Not yet Seen group, but we do not have the HEDIS age groups to stratify it as requested. We do have DOB information so age of individuals can be calculated.	3 attempts are made per patient.	
UCLA	Yes. No technical resources are available to run this data at this time.	Yes. No technical resources are available to run this data at this time.	Yes. No technical resources are available to run this data at this time.
UCSD (CHG)	# of assigned lives at any point during FY16-17 = 16,880 (This implies at any time during year, which is different from continuous coverage (enrollment during and in the last month of the PRIME measurement period without a gap in coverage of 45 days -rounded to 30 days- or more) We do not do any PCP assignments until patients are seen in clinic patients with continuous coverage = 5,681 patients with continuous coverage, Not Yet Seen = 2,382	patients with continuous coverage = 700 patients with continuous coverage, Not Yet Seen = 264 Breakdown by Age range: 10-19 2 20-29 29 30-39 48 40-49 67 50-59 92 60-69 19 70-79 6 80-89 1	3 attempts
UCSD (Molina)	# of assigned lives at any point during FY16-17 = 16,880 (This implies at any time during year, which is different	patients with continuous coverage = 5,681 patients with continuous coverage, Not Yet Seen = 2,382	3 attempts

DPH Raw Responses Regarding Plan Data Sharing – C. ASSIGNED NOT YET SEEN

	C1. Do you currently track or at least are feasibly able to ascertain for this data request % Assigned Not Yet Seen?	C2. Do you currently track or at least are feasibly able to ascertain for this data request % Assigned Not Yet Seen stratified by age (e.g. by HEDIS age groups):	• C3. Do you have a standard number of outreach attempts made by your system to individuals who are assigned but not yet seen?
	from continuous coverage (enrollment during and in the last month of the PRIME measurement period without a gap in coverage of 45 days -rounded to 30 days- or more) patients with continuous coverage = 700 patients with continuous coverage, Not Yet Seen = 264	Breakdown by Age range: 0-9 79 10-19 107 20-29 719 30-39 649 40-49 385 50-59 280 60-69 143 70-79 14	
UCSF	Based on SFHP data from August 2017: 12,463 assigned members [no continuous enrollment requirement]; of those, 10,244 (82.2%) were successfully matched to a UCSF patient ID and therefore assumed "seen".	Typically we make 3 attempts before closing an outreach case.	
VCMC	We can track this but do not do so on a regular basis. It is something we are looking to incorporate into our KPIs.	We can track this but do not do so on a regular basis. It is something we are looking to incorporate into our KPIs.	3 attempts