AHARO DATA AGREEMENT

V1.1

TABLE OF CONTENTS

INTENT

AHARO and the Health Plan ("Plan") will develop the ability to electronically exchange or share data elements to support the following:

- Monitor and improve the quality of care measures across all AHARO Members
- Measures for accountable care shared savings program to:
    - Identify a high risk cohort of patients to be tracked and followed up with care coordination and management
    - Track outpatient follow up care for recently hospitalized patients
    - Identify and reduce avoidable hospital and ED visits
    - Identify and reduce unnecessary (low complexity) ED visits
    - Identify and reduce high utilizers of hospitals and EDs
- Timely and effective care management and coordination services
- Analysis and management of risk pools to identify key areas of improvement and risk sharing among the AHARO Members and the Plan
- The Plan's analysis and reporting of HEDIS and Star performance measures
- The Plan's analysis and reporting of access to care
- Track and improve patient experience with both the AHARO Members and the Health Plan
- Capture, analysis, and incorporation of SDOH (Social Determinants of Health) into overall patient risk and care coordination and management
- Analysis and management of high utilizers and patients receiving the highest cost of care
- Analysis and improvement in the member enrollment and attribution process

HIPAA AND PHI

All data access, exchanges and sharing will be subject to all applicable HIPAA requirements, state and federal regulations, and the provisions of the non-disclosure agreement, Business Associate Agreement or this agreement, as appropriate, which is executed by both parties.

Both AHARO and the Health Plan, being Covered Entities, will transmit any PHI securely, either directly, or through an intermediary as agreed to by both parties.

Both parties agree to ensure that conveyance and use of PHI extends only to patients and patient activities, such as appointments, encounters, and claims, which are identified during the period of enrollment as assigned to an AHARO Member or the Health Plan.

DATA GOVERNANCE

All data access, exchanges and sharing will adhere to the principles and guidelines set forth within the AHARO Data Governance Charter.

All data elements listed herein shall be available to the designated AHARO steward or stewards which may include third parties for the purposes of maintenance and administration of data, including the performance of data backups and facilitating the transmission of data between AHARO, its Members, and the Health Plan.

ALL DATA ELEMENTS CONTAINING PHI AS WELL AS THE FOLLOWING LIST OF DATA ELEMENTS SHALL BE MADE AVAILABLE ONLY TO THE AHARO MEMBER FOR WHICH PATIENTS AND ALL RELATED PATIENT ACTIVITIES, INCLUDING BUT NOT LIMITED TO APPOINTMENTS, ENCOUNTERS, AND CLAIMS, ARE IDENTIFIED DURING THE PERIOD OF ENROLLMENT AS ASSIGNED BY THE HEALTH PLAN:

- Reimbursement rates and claims paid amounts (if applicable)
- _____
- _____
- _____

All other data elements listed herein, including but not limited to ethnicity, race, geographic indicators such as zip code, city, state, or island, as well as data that is derived or in aggregate form, such as denominators, numerators, or summary totals and ratios, may be shared between AHARO Members or the Health Plan so long as it adheres to the principles and guidelines set forth within the AHARO Data Governance Charter.

DATA OBJECTIVES

The following categories of data will be identified and exchanged as part of this data agreement:

- patient demographics,
- clinical,
- utilization,
- cost,
- social determinants,
- health outcome and patient experience data,
- patient enrollment status

DATA ELEMENTS

DATA TO BE SENT FROM THE PLAN TO AHARO MEMBERS

The following is a list of data elements and datasets that satisfy the intent and objectives of this agreement and will be securely accessible for download or securely transmitted from the Plan to AHARO Members. Data elements may be added or removed to meet the agreement objectives as agreed to by both parties.

MEMBER ROSTER

FILE LAYOUT

Field Name	Data Type	Description/Notes
ID	varchar(20)	If available, a unique ID in addition to their policy #
Case_ID	varchar(15)	Quest case ID
Mbr_Full_Name	varchar(255)	
Mbr_Last_Name	varchar(100)	
Mbr_First_Name	varchar(100)	

Mbr_Middle_Name	varchar(50)	
Mbr_Sex	varchar(1)	
Mbr_Date_of_Birth	datetime	
Mbr_Date_of_Death	datetime	
Mbr_Race	varchar(100)	
Mbr_Ethnicity	varchar(100)	
Mbr_Primary_Language	varchar(50)	
Mbr_Mail_Address_1	varchar(100)	
Mbr_Mail_Address_2	varchar(100)	
Mbr_Mail_City	varchar(100)	
Mbr_Mail_State	varchar(2)	
Mbr_Mail_Zip	varchar(10)	
Mbr_Mail_County	varchar(50)	
Mbr_Mail_Island	varchar(50)	
Mbr_Phy_Address_1	varchar(100)	
Mbr_Phy_Address_2	varchar(100)	
Mbr_Phone	varchar(50)	
Mbr_Email	varchar(100)	
Member_LOB	varchar(50)	
Carrier_Mbr_ID	varchar(15)	
Enroll_Effective_Date	datetime	
Enroll_Term_Date	datetime	
Program_Description	varchar(50)	Quest/Quest ABD/Medicare
Plan_Description	varchar(50)	Quest plan, e.g. QUEST KEIKI NO COPAY
PCP_Name	varchar(100)	
PCP_Effective_Date	datetime	
PCP_Term_Date	datetime	
Eligibility_Period_From	datetime	
Eligibility_Period_To	datetime	
Mbr_Months	real	Up to 1
Coverage	varchar(9)	Primary/Secondary
SPMI	varchar(3)	Yes/No

METHOD OF TRANSMISSION

Both parties will agree on method(s) of secure data transfer that will meet all HIPAA guidelines, state and federal regulations, and satisfy the requirements for transmitting the data elements in the frequency as described in this document.

Examples of acceptable secure methods of data transfer include:

- SFTP (Secure File Transfer Protocol)
- HTTPS – secure web-based download of data

FREQUENCY OF TRANSMISSION

Data to be sent monthly (minimum).

CLAIM TRANSACTIONS

FILE LAYOUT

Field Name	Data Type	Description/Notes
Form_Type	varchar(4)	1500/UB92/RX
Bill_Type	varchar(3)	3 digit type of bill
Admit_Date	date	Hospital admission date
Discharge_Date	date	Hospital discharge date
Member_LOB	varchar(50)	Medicare/Medicaid
Paid_Date	date	
Carrier_MemberID	varchar(15)	
Claim_ID	varchar(20)	Carrier unique claim ID
Claim_Line	int	line # on claim
Revenue_Code	varchar(4)	
Revenue_Code_Group_Desc	varchar(100)	
Service_Code	varchar(5)	
Service_Code_Desc	varchar(100)	
Service_Code_Cat_Desc	varchar(100)	
DOS_From	date	
DOS_To	date	
Place_of_Service	varchar(2)	e.g. 11-Office
Place_of_Service_Desc	varchar(100)	POS description
Line_Status	varchar(4)	
Billed_Amt	float	
Paid_Amt	float	
Cat_Exp_Desc	varchar(100)	
Subcat_Desc	varchar(100)	
Units	int	
Mod_Code1	varchar(2)	
Primary_Diagnosis	varchar(8)	
CCS_Diag_Group3	varchar(100)	
CCS_Diag_Group2	varchar(100)	
CCS_Diag_Group1	varchar(100)	
ER_Flag	varchar(3)	Yes/No

BH_Flag	varchar(3)	Yes/No
EM_Flag	varchar(3)	Yes/No
Claim_Source	varchar(10)	Medical/Pharmacy
Claim_Type	varchar(10)	Paper/EDI
Refill_Phar	varchar(2)	
Refill_Calc	varchar(2)	
Therapeutic	varchar(10)	
Therach1_Desc	varchar(100)	
Therach2_Desc	varchar(100)	
Therach3_Desc	varchar(100)	
Therapeutic_Desc	varchar(100)	
Drug_Name	varchar(100)	
Generic_Ind	varchar(3)	Yes/No
Drug_Quantity	float	
Days_Supply	int	
Drug_Strength	varchar(20)	
Drug_Dose_Desc	varchar(2)	
Revenue_Code_Desc	varchar(100)	
CHC_Claims_Flag	varchar(3)	Yes/No
Svc_Provider_Name	varchar(100)	
Billing_Provider_Name	varchar(100)	
30_Day_Readmit	varchar(3)	Yes/No
Service_Prov_Primary_Specialty	varchar(100)	
ICD_Version	varchar(5)	
Primary_Diagnosis_Desc	varchar(255)	
Service_Prov_Phy_Island	varchar(7)	
Service_Prov_Phy_State	varchar(2)	

Each row of the claim transactions file above represents a single transaction that can be grouped under a Claim ID.

METHOD OF TRANSMISSION

Both parties will agree on method(s) of secure data transfer that will meet all HIPAA guidelines, state and federal regulations, and satisfy the requirements for transmitting the data elements in the frequency as described in this document.

Examples of acceptable secure methods of data transfer include:

- SFTP (Secure File Transfer Protocol)
- HTTPS – secure web-based download of data

FREQUENCY OF TRANSMISSION

Data to be sent monthly (minimum).

INCREMENTAL CLAIMS TRANSACTION TRANSMISSION

TBD with each Health Plan

TOTAL COST OF CARE – SUMMARY AND DETAILED REPORTS

Health Plan shall provide Participating Federally Qualified Health Center ("FQHC") with annual and quarterly reports of the performance of Participating Federally Qualified Health Center's MCR Budget within forty-five (45) days from the end of the calendar quarter. Health Plan further agrees that such reports shall include a detailed accounting of all claims paid within that quarter and any IBNR accruals to the MCR Budget. The MCR Ratio shall equal to __ % of the actual premiums set by the State based on periodically and actuarially adjusted experience rates for the respective FQHC.

METHOD OF TRANSMISSION

Both parties will agree on method(s) of secure data transfer that will meet all regulatory guidelines that satisfy the requirements for transmitting the data elements in the frequency as described in this document.

Examples of acceptable secure methods of data transfer include:

- SFTP (Secure File Transfer Protocol)
- HTTPS – secure web-based download of data

FREQUENCY OF TRANSMISSION

Data to be sent quarterly (minimum).

DATA TO BE SENT FROM AHARO MEMBERS TO THE PLAN

HEDIS AND STAR PERFORMANCE MEASURES RELATED DATA

Below are sample file layouts from two different Health Plans. The selection of file layout to be agreed to by both AHARO and Health Plan.

FIRST FILE LAYOUT SAMPLE FROM PLAN

Field Name	Data Type	Max Length	Required	Description
MEM_NBR	Alpha- numeric	75	Y	Health Plan unique member number. The values in this file must have a corresponding value in the Member file.
SERV_DT	Date	10	Y	Date of service on professional or facility claim, the ordered date for pharmacy events
ADMIT_DT	Date	10	N	Inpatient Admit Date Only populated when part of an inpatient stay
DISCH_DT	Date	10	N	Inpatient Discharge Date Only populated when part of an inpatient stay
SNOMED	Alpha- numeric	20	N	Systematized Nomenclature of Medicine codes. Can be used in additional to CPT, ICD, REV, HCPCS codes

RXNORM	Alpha- numeric	20	N	Normalized naming system for generic and branded drugs
CVX	Alpha- numeric	5	N	Vaccine Administered code
RX_NDC	Alpha- numeric	11	N	NDC code (11-character code)
RX_DAYS_SUPP	Number	3	N	Days' supply of prescription
RX_METR_QTY	Number	12	N	Metric Quantity for the prescription drug (Decimal is accepted)
RX_DISP_DT	Number	12	N	Date medication dispensed
RX_START_DT	Date	10	N	Date the medication should start
RX_END_DT	Date	10	N	Date the medication should end if taken as prescribed
RX_ACTIVE_FLAG	Date	10	N	This field is to indicate if the member is currently on the medication, use 1= Active, 0=Inactive.
CPT	Alpha- numeric	5	N	CPT-4 procedure code
CPTMOD_1	Alpha- numeric	5	N	CPT-4 modifier
CPTMOD_2	Alpha- numeric	5	N	CPT-4 modifier
CPTII	Alpha- numeric	5	N	CPT Category 2 Codes
HCPCS	Alpha- numeric	5	N	HCPCS and CDT codes.
REV	Alpha- numeric	4	N	UB82/92 Revenue Code
POS	Alpha- numeric	2	N	HCFA Place of Service Code
ICD_FORMAT	Number	2	Y	Flag indicating ICD version. Must Have a 9 for ICD9, 10 for ICD10. Default value should be 10 if ICD Diagnosis and procedure codes are not populated
DIAG_I_1	Alpha- numeric	50	N	Principal ICD Diagnosis Code
DIAG_I_2	Alpha- numeric	50	N	Secondary ICD Diagnosis Code
DIAG_I_3	Alpha- numeric	50	N	Secondary ICD Diagnosis Code
DIAG_I_4	Alpha- numeric	50	N	Secondary ICD Diagnosis Code
PROC_I_1	Alpha- numeric	7	N	Principal ICD Procedure Code
PROC_I_2	Alpha- numeric	7	N	Secondary ICD Procedure Code
LOINC	Alpha- numeric	14	N	Logical Observation Identifiers Names and Codes for laboratory claims. Can be used in addition to CPT, ICD-9 and UB-92.
RESULT	Number	12	N	Resulting lab value or test result. The decimal point should be included. Use a null (nothing) for unknown lab value or result. For PHQ-9 administered survey populate PHQ-9 Total Score.
UNIT_TYPE	Alpha- numeric	10	N	Unit Type used for Measurement fields
USE_LAB_VALUE	Alpha- numeric	1	Y	Field must be set to 'Y' or 'N', and indicates if the lab value is to be used by the HEDIS engine or not. Set to 'Y' for lines that contains LDL-C and HbA1c results. If this field is set to 'N', then the HEDIS engine will ignore the Lab Value.

LAB_PN_IND	Alpha- numeric	1	N	Contains the Positive/Negative indicator for the lab screening, and must contain a 'P' for positive or a 'N' for negative.
RESULT_VALUE_IND	Alpha- numeric	1	N	Result value indicator. Use
			N	LOINC - L, SNOMED - S, CPT - C, HCPCS -
			N	H. (Must be populated if Value must be processed in HEDIS engine)
PROV_NBR	Alpha- numeric	75	Y	Health Plan provider number. This is the servicing provider. Use "UNKNOWN" if missing. This field cannot be '0' for Verscend retrieval clients.
CLAIM_PRAC_TYPE_ ID	Number	12	N	Claim specialty code. Not the provider specialty.
BP_SYST	Alpha- numeric	10	N	Blood Pressure Systolic value
BP_DIAS	Alpha- numeric	10	N	Blood Pressure Diastolic value
HT	Alpha- numeric	10	N	Height
WT	Alpha- numeric	10	N	Weight
BMI	Alpha- numeric	10	N	BMI value
BMI_PERCENTILE	Alpha- numeric	10	N	BMI Percentile value
EMR_RECORD_NUM BER	Alpha- numeric	100	N	Member EMR record number
FILE_ID	Number	12	Y	File ID of the source file. Default to 18000.

SECOND FILE LAYOUT SAMPLE FROM PLAN

Field Name	Data Element Description	Max Length	Data Type	Required	Format
MEMBER_SUBSCRIBER _ID	Member's Subscriber ID	32	Char	Y	
MEMBER_CTRL_NUM	Provider Medical Record Number or Control Number for the patient.	32	Char	N	
MEMBER_FNAME	Member First Name	30	Char	Y	
MEMBER_LNAME	Member Last Name	30	Char	Y	
MEMBER_SSN	Member SSN	33	Char	N	
MEDICARE_NUM	Member Medicare Number	12	Char	N	
MEDICAID_NUM	Member Medicaid Number	20	Char	N	
BIRTHDATE	Member Date of Birth	8	Date	Y	YYYYMMDD
SEX	Member Gender	1	Char	Y	M' (Male) or 'F' (Female)
PROVIDER_FNAME	Rendering Provider First Name	40	Char	Y	
PROVIDER_LNAME	Rendering Provider Last Name.	40	Char	Y	Note: If the entity is not a provider (i.e., hospital, lab or clinic), the entity name should be provided in this

					field.
PROVIDER_NPI	Rendering Provider NPI	10	Char	Y	
PROVIDERS_SPECIALTY	Reporting Provider Specialty	8	Char	Y	If the entity submitting the file is a laboratory, the specialty should be 'LAB'. Entities that are not labs should use any specialty except 'LAB'. Valid Values are listed in Appendix A.
SERVICE_DATE	Date services were performed	8	Date	Y	YYYYMMDD
PLACE_OF_SERVICE	Designates the place where the service is administered.	2	Char	Y	Valid Values are: 11…..Office
					12…..Patient's Home 22…..Outpatient Hospital 81…..Independent Laboratory
SERVICE_PERFORMED	Type of Service Performed	10	Char	Y	Valid Values are listed in Appendix B.
SERVICE_RESULT	Member Service Test Result	32	Char	Y	Valid Values are listed in Appendix B.
DIAGNOSIS1	ICD-9 OR ICD-10 Diagnosis Code 1	8	Char	Y	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS2	ICD-9 OR ICD-10 Diagnosis Code 2	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS3	ICD-9 OR ICD-10 Diagnosis Code 3	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS4	ICD-9 OR ICD-10 Diagnosis Code 4	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS5	ICD-9 OR ICD-10 Diagnosis Code 5	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS6	ICD-9 OR ICD-10 Diagnosis Code 6	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS7	ICD-9 OR ICD-10 Diagnosis Code 7	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS8	ICD-9 OR ICD-10 Diagnosis Code 8	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS9	ICD-9 OR ICD-10 Diagnosis Code 9	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS10	ICD-9 OR ICD-10 Diagnosis Code 10	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS11	ICD-9 OR ICD-10 Diagnosis Code 11	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS12	ICD-9 OR ICD-10 Diagnosis Code 12	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS13	ICD-9 OR ICD-10 Diagnosis Code 13	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS14	ICD-9 OR ICD-10 Diagnosis Code 14	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.

DIAGNOSIS15	ICD-9 OR ICD-10 Diagnosis Code 15	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS15	ICD-9 OR ICD-10 Diagnosis Code 16	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS17	ICD-9 OR ICD-10 Diagnosis Code 17	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS18	ICD-9 OR ICD-10 Diagnosis Code 18	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS19	ICD-9 OR ICD-10 Diagnosis Code 19	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS20	ICD-9 OR ICD-10 Diagnosis Code 20	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS21	ICD-9 OR ICD-10 Diagnosis Code 21	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS22	ICD-9 OR ICD-10 Diagnosis Code 22	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS23	ICD-9 OR ICD-10 Diagnosis Code 23	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS24	ICD-9 OR ICD-10 Diagnosis Code 24	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
DIAGNOSIS25	ICD-9 OR ICD-10 Diagnosis Code 25	8	Char	N	Use only valid ICD-9/ ICD-10 codes in upper case.
ICD10_IND	Indicator for ICD-9 or ICD-10.	1	Char	Y	"Y" to indicate ICD-10 "N" to indicate ICD-9 " " No diagnosis code

ACCESS TO CARE RELATED MEASURES

FILE LAYOUT

Field Name	Description	Notes
Tax_ID	Practice TIN	OPTIONAL. Practice Tax ID number. All locations should be the same.
Pat_Acct_Nbr	Patient Account Number	This is the Practice patient account number
Name	Patient LastName, Firstname	Patient Name Lastname, Firstname
DOB	Patient DOB	Patient Date of Birth
Create_Dt	Appointment Creation Date	This field is the date the appt was created. This is used for calculating # Same Day appointments (if Crt Dt = Appt Dt) * This field may not be accurately available and so another method may need to be determined for each AHARO Member
Appt_Dt	Appointment Visit Date	Scheduled Appointment Date
Loc_Name	Location Name	OPTIONAL - This field describes the Practice clinic location name (Northwest Medical, Summit View,

		etc) We use location information to provide breakdown and trend in appointment status by location.
reason_for_visit	Reason For Visit	OPTIONAL - This field is free text describing the reason for the appointment given by the patient.
event	Event / Visit Type	OPTIONAL - This field describes the appointment type as defined by practice standardized limited/restrictive list.
Status	Appt Status	This field describes the Appointment status - valid values are either the patient KEPT their appt, was a NO SHOW, or CANCELLED/RESCHEDULED
	Cancel Reason	Optional
Payer Name	Payer Name	Should be all and only UHC members
policy_nbr	Policy Number	UHC subscriber ID. This helps us to link to the MASTER ID and identify dual patients on both Medicaid and Medicare so they are not double counted.
Capacity	Total Clinic Capacity	Optional

PATIENT ASSIGNMENT STATUS

A report showing which patients are already in the EHR/EPM system and/or have been contacted by the AHARO Member.

Optional and agreed to by each AHARO Member and Health Plan.

FILE LAYOUT

TBD

CARE COORDINATION / CARE MANAGEMENT DATA

Optional and agreed to by each AHARO Member and Health Plan.

FILE LAYOUT

C-CDA (Consolidated Clinical Data Architecture) Care Plan template

Reference: http://wiki.hl7.org/index.php?title=Care_Plan_-_C-CDA_Templates_Implementation