The State of West Virginia
Bureau for Medical Services

Response to
Request for Proposal for
External Quality Review Organization
RFP #MED12009

Technical Proposal
Original

March 6, 2012

HSAG HEALTH SERVICES ADVISORY GROUP

Health Services Advisory Group, Inc. ♦ 3133 East Camelback Road, Suite 300 ♦ Phoenix, Arizona 85016
Phone: 602.264.6382 ♦ Fax: 602.241.0757

March 2, 2012

Donna D. Smith
Senior Buyer
Office of Purchasing
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100
Charleston, WV 25301

RE: Response to Request for Proposals for External Quality Review Organization, RFP #MED12009

Dear Ms. Smith:

Health Services Advisory Group, Inc. (HSAG) is pleased to submit this response to the West Virginia Department of Health and Human Resources, Bureau for Medical Services External Quality Review Organization RFP.

HSAG is eminently qualified to fulfill the External Quality Review Organization (EQRO) contract sought by the Bureau for Medical Services (BMS). HSAG brings more than 25 years of health care quality improvement experience for Medicaid, Medicare, and private health care organizations. As the provider of external quality review services in 14 states, HSAG's track record speaks for itself. HSAG has built a reputation as an innovative and collaborative partner. Moreover, HSAG is the CMS-designated Medicare Quality Improvement Organization for Arizona, California, and Florida, and holds multiple other research and review contracts in the public and private sectors. With this considerable experience, we know we can provide excellent quality review services, economically, for BMS. Consequently, we are enthusiastic to do so.

We believe our attached Technical Proposal demonstrates our skill, resources, experience and commitment to serve BMS in providing external quality review services for the West Virginia Mountain Health Trust.

Please do not hesitate to contact me if you have any questions or require clarification. I can be reached at 602.801.6701 or mdalton@hsag.com.

Sincerely,

Mary Ellen Dalton

Mary Ellen Dalton, PhD, MBA, RN
Chief Executive Officer

MED:bh

Title Page

RFP subject:	External Quality Review Organization
Number:	MED12009
Vendor's Name:	Health Services Advisory Group, Inc.
Business address:	3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501
Telephone number:	602.264.6382
Fax number:	602.241.0757
Name of contact person:	Mary Ellen Dalton, PhD, MBA, RN
E-mail address:	mdalton@hsag.com

Mary Ellen Dalton

Mary Ellen Dalton, Chief Executive Officer

2-27-12

Date

Table of Contents

Attachment A: Vendor Response Sheet

2.4.1 HSAG's Plan to Evaluate the Quality of MCOs 1
2.4.2 HSAG's Plan to Validate and Review Performance Improvement Projects 13
2.4.3 HSAG's Plan to Validate Performance Measures 24
2.4.4 HSAG's Plan to Conduct an Annual Compliance Review 35
2.4.5 HSAG's Plan to Monitor Medicare and Private Standards and Processes for Review and Make Recommendations to BMS 54
2.4.6 HSAG's Plan to Review Unique MCO Activities 63
2.4.7 HSAG's Plan to Accurately and Reliably Summarize the Performance of each MCO 72
2.4.8 HSAG's Plan to Develop a Detailed Technical Report 80
2.4.9 HSAG's Plan to Develop Annual Plan-Specific Reports 91
2.4.10 HSAG's Plan to Develop a Comparative MCO Report 100
2.4.11 Yearly Operations Plan 109
2.4.12 HSAG's Expertise with Federal Statutes, Regulations, and Guidance 110
2.4.13 HSAG's Knowledge of "Best Practices" 112
2.4.14 Vendor References 115
HSAG's EQRO and QIO Contract Experience 120

Attachment B: Mandatory Specification Checklist

2.5.1 Compliance with requirements in Attachment D 1
2.5.2 Lead point of contact 1
2.5.3 Training and technical assistance 2
2.5.4 Compliance with federal regulations 3
2.5.5 Prepare and submit draft work plan 22
2.5.6 Project manager attendance of quarterly meetings 22
2.5.7 Quarterly written status reports 22
2.5.8 Providing additional services 22

Attachment C: Cost Sheet

Attachment D: Special Terms and Conditions

Appendix

Required Forms
Corporate Licenses and Certifications
Sample Report
Vendor Registration

Attachment A: Vendor Response Sheet

Provide the following: firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met.

Also, describe the approach and methodology proposed for this project. This should include how each of the goals and objectives listed is to be met.

The Vendor should address within their proposal how they are able to:

- Identify any issues or problems regarding access, quality, and utilization;
- Verify MCO compliance with program systems and clinical requirements, as outlined in the MCO contract;
- Identify "best practices" and work with MCOs to improve results;
- Provide BMS with a comprehensive report that can be used as part of the Bureaus' overall quality strategy; and
- Prepare BMS and the MCOs for fall review activities that will take place during the year. This approach should include an onsite orientation meeting with the MCOs and BMS.

2.4.1 HSAG's Plan to Evaluate the Quality of MCOs

2.4.1 Vendor should propose an organized, integrated plan to evaluate the quality of MCOs participating in the West Virginia MHT program. The work plan should specifically address how the Vendor conducts all EQR activities and reporting requirements in the most efficient way for both State and MCO staff. The work plan should establish time estimates for each significant segment of work that demonstrates the Vendor's ability to comply with expected timeframes in Section 2.5.5 of this RFP.

Experience With Similar Projects

Since 1983, Health Services Advisory Group, Inc. (HSAG), has been actively engaged in evaluating the quality of care that Medicaid recipients receive. Currently, HSAG provides external quality review (EQR) services in California, Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, Tennessee, Vermont, and Washington, which together include more than 30 million Medicaid recipients. HSAG performs its external quality review organization (EQRO) functions in accordance with federal and state laws, regulations, and policies regarding Medicaid—including standards and procedures pertaining to the terms and conditions of the applicable waiver programs.

With more than 25 years of experience managing multiple large-scale contracts for state and federal agencies, HSAG has refined its project management processes. HSAG's successful track record in managing these contracts has been made possible by HSAG's:

- Focused approach to managing projects that emphasizes efficient and cost-effective achievement of specific outcomes
- Exceptionally high-caliber professionals and support staff
- Systems, relationships, and resources that support all work efforts
- In-depth experience over the years
- Successful collaboration with carefully selected subcontractors

HSAG focuses on collaboratively developing project plans that incorporate input from key stakeholders, beginning with the state Medicaid agency. The project approach and methodology are carefully thought out to ensure that all tasks, subtasks, and resources are necessary for the achievement of the desired outcomes and the timely completion of quality deliverables. Problems and issues are identified during HSAG project team meetings, which include state Medicaid agency staff members. Such issues are assigned to a team member for resolution, tracked, and reported at future meetings.

HSAG is confident in our ability to implement and manage contracts. We have done so successfully in multiple settings—to the ultimate satisfaction of our clients.

HSAG believes there are four major elements to the project management plan:

- Implementation—establishing our project staff and the development of a partnering relationship with the Medicaid agency staff
- Structure—establishing the appropriate organization, using subcontractors as appropriate, with the direction to act for the betterment of the EQRO project
- Support—ongoing access to subject matter experts, including HSAG senior staff members as well as subcontractor experts
- Reporting—keeping the state Medicaid agency informed on implementation status, operational status, and issues on an ongoing basis

HSAG uses a project quality management approach that includes the processes required to ensure that the project satisfies the needs of the state Medicaid agency. It includes all activities of the overall management function that determine the project quality, objectives, and responsibilities, and implements them by quality planning, quality control, quality assurance, and quality improvement within the system. The following is an overview of the major project quality management processes:

Project quality planning—In conjunction with the state Medicaid agency, HSAG identifies and implements applicable quality standards for this project. In this phase, quality checklists play a vital role and are used to verify that the required steps in any one or a number of tasks have been performed.

Project quality assurance—Planned and systematic activities are implemented throughout the project to ensure the state Medicaid agency's quality standards are met.

Project quality control—HSAG monitors specific project results to determine if they comply with relevant quality standards and identifies ways to eliminate causes of unsatisfactory results. Project results include deliverables and management results such as cost and schedule performance. Quality controls are used to track the status of the project through quality checkpoints and monitoring.

Project quality improvement—Actions are implemented to increase the effectiveness and efficiency of the project and to provide added benefits to the state Medicaid agency.

> ***HSAG believes that the benefits of meeting quality requirements include higher productivity, improved relationships, and increased state Medicaid agency satisfaction.***

HSAG's goal in building upon its quality control procedures is to improve HSAG responsiveness, accountability, and outcomes.

Team Approach to Project Management

HSAG recognizes the importance of having a well-qualified staff along with a commitment to proactive communications with each state Medicaid agency. HSAG's experience with its EQRO contracts has demonstrated that timely and frequent communication with each state Medicaid agency increases HSAG's understanding of the project and significantly contributes to the success of the project.

The HSAG project team represents a management team structured to provide innovative and efficient direction for EQRO project activities. HSAG has organized this team to meet contractual requirements and to best utilize the professional skills of its members. In addition to possessing an optimum blend of skills and experience, team members are strong in individual capabilities and flexibility that assist the smooth flow of work, communication, and success in meeting each agency's objectives. The multi-functional capacity of the team is the key strength for this project.

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is Executive Director, State & Corporate Services Division for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debbie Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work, contract deliverables, and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and

objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with Balanced Budget Act of 1997 (BBA) requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, MBA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which time she reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Before joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She

currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Wendy Talbot, MPH, CHCA, is an Associate Director of Audits at HSAG and is responsible for the oversight and management of HSAG's NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit program as well as the Validation of Performance Measures activities for its EQRO contracts. Prior to her appointment to her current position, Ms. Talbot served as the Arkansas project manager, overseeing the day-to-day contract activities for HSAG's Arkansas data mining and program evaluation contract. She was also a project manager within the Audit Department, where she was responsible for support of the HEDIS audit program and all performance measure validation activities, including communicating with health plans, preparing agendas and scheduling and conducting site visits, reviewing the systems capabilities tools completed by the health plans, reviewing programming logic and output files, and compiling audit results into a final audit report. Ms. Talbot is an NCQA-Certified HEDIS Compliance Auditor, and she is skilled in primary source verification of eligible population and numerator files, ensuring algorithmic compliance, and assessing bias using NCQA and CMS techniques and protocols.

Her previous roles at HSAG included project coordinator for performance improvement projects, performing validation of physical and behavioral health PIPs, and participating on external quality review and compliance audits of Michigan mental health plans. She also served as a health care analyst with HSAG's Federal Division, providing analytic support for the CMS 7th Scope of Work quality improvement organization (QIO) contract and analyzing and reporting on ambulatory care and inpatient data, including mammography, diabetes, and immunizations.

Ms. Talbot has more than seven years of experience in epidemiology, data analysis and management, and health care/disease program management with state Medicare/Medicaid programs. She holds a Bachelor of Science degree in Health Sciences from the University of Nevada at Reno and a Master of Public Health degree from the University of Arizona, with emphasis in epidemiology.

Gretchen Thompson, MBA, CPHQ, is an Executive Director for HSAG's State & Corporate Services Division. Ms. Thompson is responsible for overseeing the Performance Measure Validation (PMV) and PIP Validation teams. Ms. Thompson has more than 14 years of experience in Medicaid and has worked in a number of different Medicaid delivery systems, such as managed care, fee for service, long term care, physical health, and behavioral health. Ms. Thompson has an extensive background in federal and state health care policy, data systems, and quality assessment and performance improvement. In her current position, Ms. Thompson oversees the development of all project deliverables and is responsible for the quality of all work performed by PIP and PMV staff members, ensuring client satisfaction with the work product provided.

Prior to joining HSAG, Ms. Thompson was President of Pinnacle Strategies, a private health care consulting firm focusing on strategic planning, business development, quality improvement and

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

compliance, Medicaid waiver program development and implementation, and initiatives to improve health care for seniors and people with disabilities. She has also worked for a national managed care organization designing and implementing high-quality cost savings health care programs, and developing new health care program initiatives in Medicaid and other public sector health care programs. At the request of the National Advisory Board on Improving Health Care for Seniors and People with Disabilities, Ms. Thompson authored the community mobilization white paper, *Declaration for Independence: A Call to Transform Health and Long Term Services for Seniors and People with Disabilities.* Ms. Thompson was also a member of the Heinz Family Philanthropies consulting team for projects involving 340B pharmaceutical research and analysis and health care reform.

Ms. Thompson holds a Bachelor of Arts Degree in Psychology from Arizona State University and a Master of Business Administration Degree from the University of Phoenix. She is also a Certified Professional in Health Care Quality (CPHQ) from the Healthcare Quality Certification Board.

Christi Melendez, RN, **CPHQ,** is the Associate Director of Quality Improvement Projects at HSAG and is responsible for leading the plan-specific, small-group, and collaborative PIP validation activities and tasks performed by the HSAG PIP Validation Team. Ms. Melendez has been with the company since 2001. She has more than 20 years of nursing experience in the clinical and home health settings, including case management and medical record reviews. In her current role, she works closely with the PIPs manager to validate health plan performance improvement projects by assessing the implications on the validity and reliability of the PIP findings. Ms. Melendez is responsible for providing technical assistance and training to states, as needed. In addition, she is also an RN abstractor/coordinator, performing review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She has assisted in the training of other RN abstractors and has provided on-site medical reviews for HEDIS auditing.

Ms. Melendez's prior experience includes 14 years of case management of long-term, chronically ill children, maternity and pediatric patients, and home health infusion patients. She was responsible for preparing quality assurance and treatment plans as well as performing medical record/documentation audits. She was actively involved in performance improvement activities.

Ms. Melendez is a Registered Nurse with an Associate of Science Degree in Nursing from Cypress College in California. She recently became a Certified Professional in Healthcare Quality (CPHQ).

Diane Christensen, LPC, is a Director, EQRO Services with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for the division's projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Masters of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Tom Miller, MA, is Executive Director, Research and Analysis Team, and has been with HSAG since December 2003. In his current role, Mr. Miller is responsible for oversight of all State & Corporate Services Division analysis activities and staff, including coordinating all HSAG analytic activities, implementing quality control processes, and training and oversight of State & Corporate analysts. Mr. Miller has more than 10 years of experience performing statistical analysis in the health care setting, including Medicaid managed care, pharmacy benefit management, disease management, and claims processing. He has extensive experience managing retrospective and survey research studies and encounter data validation studies involving the coordination of internal and external customers. Mr. Miller has worked with NCQA/QISMIC Accreditation Standards and HEDIS performance measures (including work with Consumer Assessment of Healthcare Providers and Systems [CAHPS®])[2]. He has performed highly technical data manipulation/analysis to render meaningful interpretations, and to translate quantitative and qualitative research into operational goals and standards and improvement activities.

As head of the Analysis Team, Mr. Miller provides research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytical staff. He has been involved in designing and executing numerous focused studies, including evaluations of perinatal care, asthma management, lead screening, adolescent health care, and childhood immunizations in Ohio; perinatal care, asthma management, preventive services for persons with disabilities in Colorado; and EPSDT services for school-aged children in Michigan. Mr. Miller has also been involved in conducting encounter data validation activities for physical health programs in

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Hawaii, Ohio, and Tennessee; and for prepaid mental health plans in Utah. Additionally, Mr. Miller has worked on a variety of other projects, including case management reviews in Arizona and Ohio, HEDIS reporting in Florida, Ohio, and Michigan, evaluation of provider networks and benefit delivery in Tennessee and Nevada, Medicaid provider surveys in Colorado, and coordination of compliance audit sampling activities. He acts as a SAS and GeoAccess expert resource for the Research and Analysis Team.

Mr. Miller holds a Bachelor of Science Degree in Sociology and Psychology from Northern Arizona University and a Master of Arts Degree in Sociology from the University of Cincinnati. He is a member of the AcademyHealth organization.

Barbara McConnell, MBA, OTR, is a Project Director for the State & Corporate Services Division at HSAG. She is responsible for analyzing and evaluating pertinent information for physical and behavioral health organization on-site reviews, and for coordinating various contract activities and deliverables. Ms. McConnell is responsible for reviewing desk audit materials, on-site audit activities, and preparing the report of audit findings for HSAG's Colorado physical and behavioral health EQRO contract. She also participates as part of the compliance team for on-site reviews in multiple other states, which includes reviewing organizational standards and compliance, assisting the project team with accurate and supportive recommendations, and providing client feedback and reports on review findings in follow-up to site visits.

Ms. McConnell is a registered occupational therapist with over 20 years of experience in a variety of health care settings, including mental health centers, hospitals, and rehabilitation centers. She also brings a thorough knowledge of the start-up and ongoing management of rehabilitative facilities, from development of collaboratives in the community, working with funding sources such as Medicare and Medicaid, and coordinating care plan programs to ongoing case management and quality improvement/assurance.

Ms. McConnell holds a Bachelor of Science Degree in Occupational Therapy from Ohio State University and a Master of Business Administration Degree from the University of Kansas.

Cheryn Wall, EdD, is Director of HSAG's Reports Team. She has been with HSAG since December 2002 and has more than 20 years of experience writing, editing, and producing data-driven reports for local, state, and federal projects. Dr. Wall works with the EQRO Executive Directors to develop work plans for all report deliverables, and supervises the reports team members to translate these work plans into daily, manageable workloads. She has been an editor/writer for various reports, required filings, RFP and grant applications, company and community newsletters, annual reports, research findings, speeches, news releases, press packets, and other deliverables. She has also authored/co-authored published articles, columns, and information pieces. Dr. Wall has served as a consultant on communication strategies and educational training programs. She has taught oral and written communication skills courses at the university level as an assistant professor (part-time).

She has a Bachelor's and a Master's degree in Communication and a Doctorate in Educational Administration and Supervision.

Proposed Approach and Methodology

As described in detail in subsequent sections of this proposal, HSAG has a tried and true method of working with its EQRO clients to perform EQR activities and assisting states with monitoring and evaluating the quality of Medicaid services being provided and the degree to which the managed care organizations (MCOs) meet state and federal requirements. In this section, HSAG outlines the major overall approaches HSAG will take to the requested Scope of Work for the State of West Virginia, Bureau for Medical Services (BMS).

HSAG will ensure:

Assignment of knowledgeable and qualified EQR team members—HSAG has assembled a seasoned team of professionals to work directly with BMS on all EQR-related contract activities. The team will receive executive level leadership and oversight, and each task team will be led by a subject matter expert who has overall responsibility for the specific EQR activity. HSAG's West Virginia EQRO team has mechanisms in place for regular internal communication and coordination as a team to provide project status updates and share relevant information across all scopes of work. The executive and project directors will be responsible for continually facilitating the transfer of knowledge about the Mountain Health Trust (MHT) program and the Medicaid MCOs to the team members as information is gained, so that the team understands the population, program requirements, quality goals, and priorities of the State. Descriptions of each team member's background, experience, and qualifications (including copies of their degrees and certifications) have been provided within this proposal.

Effective communication and collaboration with the State and its contractors—HSAG's approach to its EQR activities is one of collaboration with a state's Medicaid agency and its MCOs in planning and scheduling each of the contracted activities. A key to its success is its commitment to open and frequent communication with the state agency to ensure that its project activities and deliverables meet the contract requirements and the state's expectations. The West Virginia Project Lead will be the day-to-day point of contact for BMS, and will be immediately available via phone and e-mail during business hours (8 a.m. to 5 p.m. Eastern Standard Time) Monday through Friday. In addition, HSAG proposes to schedule monthly one-hour telephonic progress meetings with BMS to review HSAG's accomplishments in the prior month; review the project activities and tasks under way in the current month; and discuss and resolve any barriers, delays in receiving data or information from the MCOs, or any other outstanding issues that may impact progress or timelines. During this monthly meeting, HSAG will also discuss and reach agreements with BMS about timelines for the BMS staff to review and approve HSAG's draft tools, report templates, and preliminary reports of results.

Efficient use of time and other resources—BMS, MCOs, and HSAG—HSAG is aware that states and MCOs have multiple other priorities and potential resources limitations. Therefore, HSAG is flexible, responsive, and respectful when planning and conducting the EQR activities, and for such things as determining turn-around times for feedback from the state and MCOs when requesting information, documentation, or review and comments. HSAG is also sensitive to the costs (both human and financial) for the exchange of documents between HSAG and states and their MCOs, as required during the EQR activities. HSAG uses many options that reduce or

eliminate the need for producing or preparing paper/hard copies, including a secure file transfer protocol (FTP) site for uploading documentation, compact discs (CDs), e-mail, and Web-Ex conferencing with the sharing of desktops to view documents on the computer. HSAG also researches and obtains state and MCO documents via the Internet so as to not request information that is available in the public domain.

Orientation to all activities—HSAG will prepare and deliver an on-site orientation and training session that provides BMS and its MCOs with a clear picture of how the EQR activities will be conducted by HSAG, the responsibilities of each party for participation in the activities, and the timelines and due dates for the specific tasks within each activity. Throughout the duration of the activities, HSAG will be available for additional technical assistance to individual or groups of BMS and MCO staff members as questions or barriers arise, to ensure that projects stay on track for timely, successful completion. HSAG has provided such orientation sessions in most of its EQRO-contract states.

Timely required reporting—In addition to monthly progress calls with BMS and written monthly progress summaries, HSAG will produce and submit to BMS quarterly written status reports within 15 calendar days of the end of each quarter for the duration of this contract. Following finalization and approval of HSAG's work plan and timelines for conducting the EQR activities and delivering draft and final reports, HSAG will ensure that it diligently tracks and meets the required reporting and deliverable due dates. HSAG will also ensure the timely reporting, on an ad hoc basis, of any issues identified that threaten the timely completion of an activity or deliverable, and will work with BMS (or the MCOs, as needed) to resolve the issues causing the delay.

Attendance at quarterly meetings—HSAG's West Virginia Project Lead will attend the quarterly meetings of the Mountain Health Trust Task Force in person, participate as needed, and communicate relevant program information to the HSAG team.

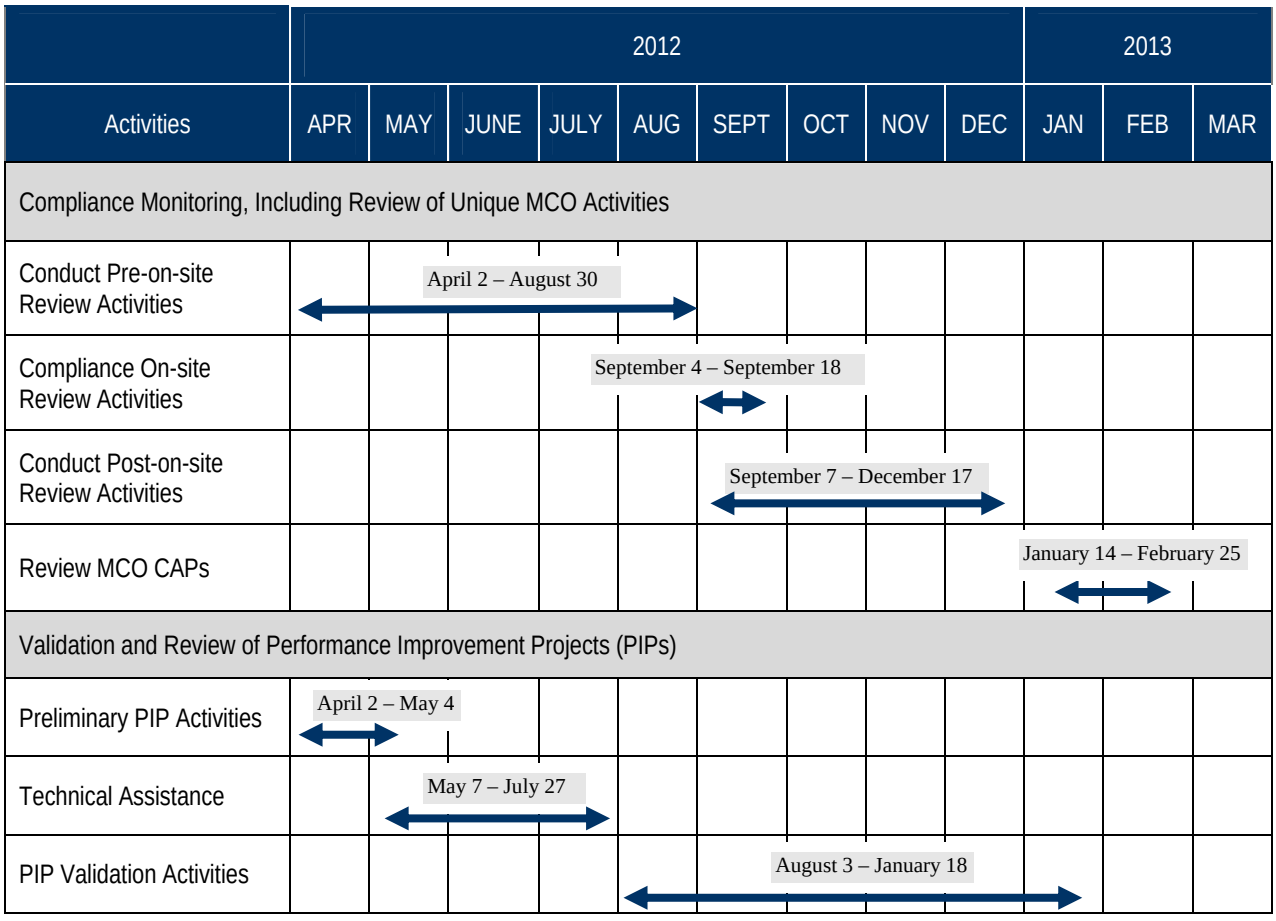
Short- and Long-term Project Planning—Within 30 calendar days of contract award, HSAG will prepare and submit a written draft work plan for review and approval by BMS. Although HSAG has submitted a detailed work plan within this RFP proposal for each of the EQR-related activities, it stands ready to hold a dialogue with the State regarding requirements and preferences for activity timelines and sequencing, and will make these revisions to the work plan as needed. HSAG will continually monitor its project timelines, deliverables, and milestones throughout the duration of the contract. An integrated, high-level annual project plan timeline is also being provided at the end this section to give BMS a "snapshot" of the time estimates for each significant segment of work associated with the EQR activities.

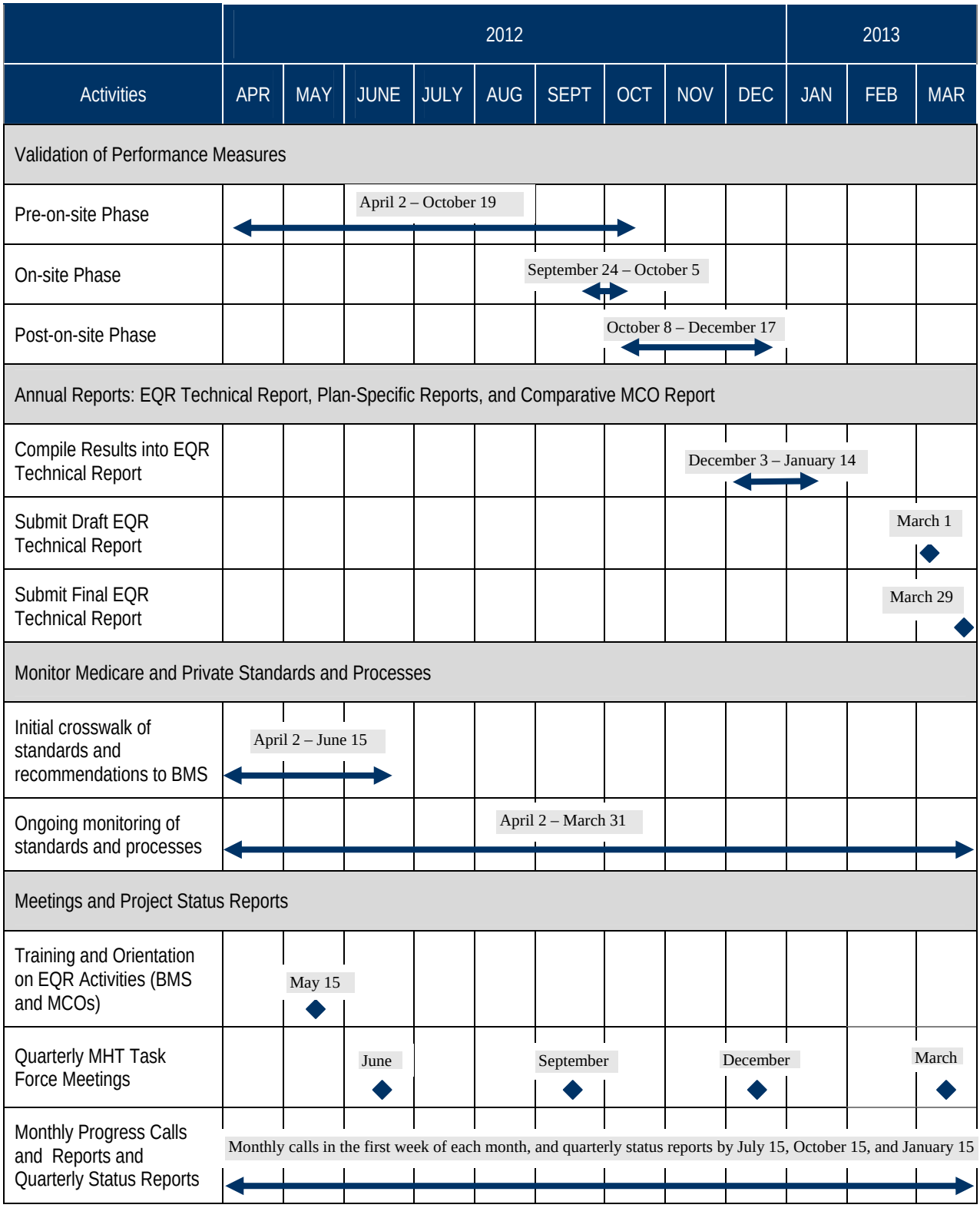
For each state Medicaid agency where HSAG has an EQRO contract, HSAG also prepares a one-year, two-year, three-year, and up to a five-year strategic plan. On an annual basis, prior to the end of each EQRO contact year, HSAG has a strategic meeting with the Medicaid agency to discuss what might be done differently and/or better in the upcoming year and, if indicated or requested by that state, shifts the focus or the resources from any optional activities to areas identified to have more significant need. For example, it was HSAG's recommendation in one state to provide targeted technical assistance on-site to the MCOs and eliminate a focused study.

Based on an analysis of the previous year's activities, corrective action plans (CAPs) required by the MCOs, data and information on the best practices, and high levels of performance and opportunities for improvement demonstrated by the MCOs, HSAG (in collaboration with BMS) will determine any specific areas to be addressed and targeted for improvement for the following year's EQR activities. Also, as CMS provides new guidance or clarifications, communicates its priorities for national health outcomes, or makes changes in federal Medicaid program requirements, HSAG is prepared to modify staff and resources to accommodate the change rapidly and efficiently at the direction of the State. HSAG will provide any services needed to comply with these externally driven program changes at the hourly rate described in the cost proposal, and will determine in collaboration with BMS the scope, approach, methodology, timeline, and deliverables required for any such additional work under this contract.

Upon contract award, HSAG will schedule an on-site contract "kickoff" meeting with BMS, with a well-planned agenda that will serve to initiate the working relationship, clarify expectations and agree on timelines, exchange information and key documents, and begin all necessary planning for the contract activities.

Integrated, High-Level Annual Project Plan Timeline




2012
2013
Activities
APR
MAY
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
JAN
FEB
MAR
Validation of Performance Measures
Pre-on-site Phase
April 2 – October 19
On-site Phase
September 24 – October 5
Post-on-site Phase
October 8 – December 17
Annual Reports: EQR Technical Report, Plan-Specific Reports, and Comparative MCO Report
Compile Results into EQR Technical Report
December 3 – January 14
Submit Draft EQR Technical Report
March 1
Submit Final EQR Technical Report
March 29
Monitor Medicare and Private Standards and Processes
Initial crosswalk of standards and recommendations to BMS
April 2 – June 15
Ongoing monitoring of standards and processes
April 2 – March 31
Meetings and Project Status Reports
Training and Orientation on EQR Activities (BMS and MCOs)
May 15
Quarterly MHT Task Force Meetings
June
September
December
March
Monthly Progress Calls and Reports and Quarterly Status Reports
Monthly calls in the first week of each month, and quarterly status reports by July 15, October 15, and January 15

2.4.2 HSAG's Plan to Validate and Review Performance Improvement Projects

2.4.2	The Vendor should propose a plan to validate and review PIPs as required by 42 CFR §438.358(b)(1). The Vendor should propose a plan to validate PIPs required by the State that were underway during the preceding twelve (12) months, to comply with requirements set forth in 42 CFR §438.240(b)(1). The plan should describe how the Vendor assess the study and methodology for conducting the PIPs, verify actual PIP study findings, evaluate overall validity and reliability of study results, and monitor performance indicators after completion of the PIP to ensure sustained improvements.

Experience With Similar Projects

HSAG successfully validates more than 300 PIPs each year in 10 states (California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, and Vermont). HSAG can provide BMS and the MCOs with insights and best practices gained from having validated PIPs on a vast number of topics, such as childhood obesity, diabetes care, reducing avoidable emergency room visits, coordination of care, access to care, mental health follow-up, utilization measures, seclusion and restraint reduction, prenatal care, consumer satisfaction, and timeliness of care. HSAG has extensive experience in assisting MCOs with conducting PIPs that are focused on topics for women and children's preventive health services. Currently, HSAG is facilitating a collaborative PIP with the HMOs in Florida for Well-Child Visits in the First 15 Months of Life—Six or More Visits.

In addition to working with acute care health plans, HSAG validates PIPs for health plans whose populations are dually eligible for Medicaid and Medicare services and have complex health conditions and long term care needs. Because of the experience they have gained in working with these health plans, HSAG staff members are uniquely positioned to provide technical assistance and facilitate discussions that assist the health plan staffs in identifying PIP study topics, indicators, and interventions that are focused on elderly persons and people with disabilities. A sampling of clinical and nonclinical PIP study topics that are validated by HSAG for this population include:

- Improving the Percentage of the Frail Elderly Who Execute an Advance Directive
- Using Home Monitoring Telehealth to Improve 30-day Readmission Rates for Clients Diagnosed with Cardiac Disease
- Reducing Hospital Readmissions
- Improving the Timeliness of Home Health Services
- Improving the Rate of Influenza Vaccines

Since the inception of HSAG's PIP validation process, the CMS protocols have been used to guide the development of the tools and internal review and evaluation processes. HSAG's approach to PIP validation has evolved based on input provided by health plans and states, and HSAG has modified its tools to better assist health plans in documenting their PIPs. HSAG's tools and approach to PIP validation have been reviewed and supported by CMS, which stated that:

"The PIP summary form and validation tool developed by HSAG were outstanding."

HSAG's PIP Summary Form and its accompanying completion instructions will be provided to MCOs to aid in the documentation of the PIP. The PIP Summary Form, which was designed after the CMS protocols for conducting PIPs, guides MCOs to include applicable and appropriate information to demonstrate the MCOs' compliance with each of the 10 steps in the CMS protocols for conducting a PIP. The completion instructions describe the requirements of each of the elements to be completed by the MCO in the PIP Summary Form and provide step-by-step instruction on how to document the PIP.

Proposed Approach and Methodology

HSAG's PIP validation process not only evaluates the PIPs' compliance with the CMS Protocol documentation requirements and the reliability and validity of the reported results, but it also provides feedback on the study indicator outcomes. This type of feedback assists health plans with developing methods to determine the efficacy of their interventions and how to target improvement strategies that bring about true improvement.

The primary objective of PIP validation is to determine each plan's compliance with federal requirements, which include:

- *Measuring* performance using objective quality indicators.
- *Implementing* systematic interventions to achieve improvement in quality.
- *Evaluating* the effectiveness of the interventions.
- *Planning* and *initiating* activities to increase or sustain improvement.

The following specific steps describe HSAG's approach and methodology for reviewing and validating PIPs.

Assess the Study and Methodology for Conducting PIPs

Using the CMS Protocol, *Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002*, as its foundation, HSAG classifies the progression of PIPs into three study stages: design, evaluation and implementation, and outcomes.

Study Stage	Activity	
Design	I.	Select Study Topic(s)
	II.	Define the Study Question(s)
	III.	Select the Study Indicator(s)
	IV.	Use a Representative and Generalizable Study

Study Stage	Activity	
		Population
	V.	Use Sound Sampling Techniques (if sampling was used)
	VI.	Reliably Collect Data
Evaluation/Implementation	VII.	Analyze and Interpret Study Results
	VIII.	Implement Intervention and Improvement Strategies
Outcomes	IX.	Assess for Real Improvement
	X.	Assess for Sustained Improvement

To assess the MCOs' PIP study and methodology, HSAG will request that MCOs submit their PIPs with the data obtained from conducting the PIPs within the preceding 12 months. Given that these PIPs were already under way, HSAG anticipates that the first PIP submissions to HSAG will contain Baseline and possibly Remeasurement 1 data. In the first year of the contract, HSAG requests that MCOs complete and submit to HSAG a PIP Submission Form for each PIP, which will be completed through Activity VIII, *Implement Intervention and Improvement Strategies*. HSAG will evaluate the PIP's study design, methodology, and planned interventions based on the data provided by the MCO. Specifically, HSAG will evaluate the PIP based on the following 10 activities:

Activity I. Review the selected study topic(s). HSAG will assess and verify whether data collection and analysis of MCO beneficiary needs, care, and services support the necessity to conduct the PIP; the PIP targets improvement in relevant clinical care and nonclinical services; the PIP is representative of the MCO's population; there are sufficient sources for data collection; and the MCO can impact change in the area under study.

Activity II. Review the study question(s). HSAG will verify whether the MCO's study question(s) are clearly defined in writing and are answerable. The study question(s) must demonstrate how the MCO will maintain the focus of the PIP and set the framework for data collection, analysis, and interpretation.

Activity III. Review the selected study indicator(s). HSAG will evaluate whether the MCO's study indicators are measurable, clearly defined, pertinent to the study question, have adequate data sources, address limitations on collecting data, have clearly defined criteria for data collection, measure process and outcomes of care, and have realistically set performance goals and benchmarks based on a literature review and industry standards.

Activity IV. Review the identified study population. HSAG will evaluate how the study population is defined; whether all individuals relevant to the study question and indicators are included, or whether a sample of these individuals is included; whether any continuous enrollment criteria are defined; and whether the data collection plan ensures the capture of all individuals in the study population.

Activity V. Review sampling methodology (if sampling was used). HSAG will evaluate if the study sample is derived in accordance with generally accepted principles of research design and

statistical analysis, is sufficient to make meaningful conclusions, and will provide valid and reliable results.

Activity VI. Review data collection procedures. HSAG will assess if data collection techniques comply with industry standards; data collection is performed in a way that preserves internal and external validity; the method for calculating indicators is appropriate; and the algorithm for extracting automated information systems data is sound/accurate.

Activity VII. Review data analysis and interpretation of study results. HSAG will evaluate whether data analysis techniques comply with industry standards; appropriate statistical tests are used and accurate/reliable information is obtained; interpretation and analysis are based on continual improvement philosophies and causes are appropriately attributed to findings; and study results are communicated to appropriate internal committees and external entities.

Activity VIII. Assess improvement strategies. HSAG will verify whether the barrier analysis process is adequate to identify opportunities for improvement, whether appropriate improvement strategies are developed, and if the timeline for implementation of interventions is reasonable. The effectiveness of the intervention activity or activities is determined by measuring the MCO's change in performance.

Activity IX. Assess the likelihood that reported improvement is real improvement. HSAG will verify that significant improvement has been achieved and that reported improvement in process or outcomes of care represent actual improvement. HSAG will assess the extent to which any change in performance reported by the MCO is statistically significant.

Activity X. Assess whether documented improvement has been sustained to determine if the process can reasonably ensure continued improvement over time. HSAG will assess if real change results from changes in health care delivery that can be documented by the MCO. HSAG's approach to assessing for sustained improvement is to evaluate a baseline and a minimum of two annual remeasurements.

Verifying Actual PIP Study Findings

To verify actual PIP study findings, HSAG will ensure that the study indicators are included in the list of performance measures that HSAG will validate on an annual basis as part of its performance measure validation (PMV) activities. This activity will include an evaluation of the accuracy of the PIP indicator reported by the MCO and a determination of the extent to which the specific PIP indicators calculated by the MCO followed specifications established for the indicator. HSAG will determine if any discrepancies exist within the reported PIP data and alert BMS to the findings.

Evaluate Overall Validity and Reliability of Study Results

The validation process includes structured assessment and scoring methods and also includes an interrater reliability verification process to ensure that the CMS Validation Protocols are consistently applied by multiple PIP reviewers. Given HSAG's structured method of assessing PIPs, each state contracted with HSAG has demonstrated improvement in the reliability and validity of its PIPs and, subsequently, in many cases has experienced a favorable effect on

Medicaid beneficiary health outcomes, which is the ultimate goal of a PIP.

Each required activity consists of evaluation elements necessary to complete a valid PIP. HSAG will score the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To further ensure a valid and reliable review, HSAG designates some of the elements as critical elements. All of the critical elements must be *Met* for the PIP to produce valid and reliable results. For example, for Activity II (Valid Study Question), if the study question could not be answered, then the critical element would be scored as *Not Met* and the PIP would not be valid.

The following is an example of how critical elements are designated in HSAG's PIP Validation Tool.

	Evaluation Element	Scoring
Critical Element	The written study question is answerable.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A

HSAG assesses each evaluation element, scores it as noted above, and creates a table that totals all scores (for critical and noncritical elements). From this table, HSAG calculates the percentage scores and a validation status. The percentage scores are calculated by dividing the total number of elements (including critical and noncritical elements) that were *Met* by the sum of the total number of elements that were *Met*, *Partially Met*, and *Not Met*. The percentage of critical elements *Met* is calculated by dividing the total number of critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*. The validation status score is based on the percentage score and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

A PIP that accurately documents CMS Protocol requirements has high validity and reliability. *Validity* is the extent to which the data collected for a PIP measure its intent. *Reliability* is the extent to which an individual can reproduce the study results. For each completed PIP, HSAG assesses threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible. Using its PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- ***Met*** = high confidence/confidence in the reported study findings.
- ***Partially Met*** = low confidence in the reported study findings.
- ***Not Met*** = reported study findings that are not credible.

For PIPs that receive a *Met* validation status, HSAG will recommend that the MCO continue with the progression of the PIP until it achieves statistically significant and sustained improvement. For PIPs that receive a *Partially Met* or *Not Met* validation status, HSAG will recommend that the MCO address all *Partially Met* and *Not Met* evaluation elements prior to continuing the PIP.

HSAG will produce an MCO-specific PIP Validation Report that will include organized, aggregated analysis of PIP data that draws conclusions about the study indicator outcomes and the MCO's quality improvement efforts. The PIP report will discuss both the technical methods

of the PIP (i.e., the study design) and the outcomes associated with the implementation of interventions. Based on the PIP validation, HSAG determines the overall methodological validity of the PIPs. In addition, the MCO-specific report will outline the MCO's strengths, opportunities for improvement, and HSAG's recommendations. This type of feedback assists MCOs with developing methods to determine the efficacy of their interventions and how to target improvement strategies that bring about true improvement.

Monitor Performance Indicators after Completion of the PIP

HSAG recommends that after a PIP has been retired, that the MCOs continue to report the indicators as part of their list of required performance measures. HSAG will continue to validate and monitor the indicators annually through the PMV audit. This process will enable HSAG to continually monitor an indicator's performance long after the PIP has been retired, and notify BMS if a decline in performance is detected.

Identifying Issues Regarding Access, Quality, and Utilization

The purpose of a PIP is to improve performance in a targeted area. For MCOs, this often means that targeted improvement is necessary to improve access to care, quality of care, or appropriate utilization of care for beneficiaries. MCOs should regularly collect data on performance measures and beneficiary health outcomes and evaluate the data to determine areas requiring improvement. Ideally, the MCOs will develop performance improvement projects to address areas of low performance. As HSAG reviews MCO PIP indicator data and the barrier analyses provided by MCOs (through the completion of Activity VIII), HSAG will be able to identify any primary or secondary issues that impede access, quality, or utilization of services that might not otherwise be discovered. For instance, if an MCO identifies a barrier in collecting laboratory claims data in Activity VIII of its PIP, to *Improve the Rate of Chlamydia Screenings for Women*, it is probable that this barrier will also impact the MCO's ability to collect laboratory data for other HEDIS measures, such as Cervical Cancer Screening and Prenatal Care. Likewise, if an MCO identifies an access-related barrier for children to receive well-care visits, it is likely that the access-related barrier will impede other beneficiaries from accessing preventive care. HSAG will work with BMS and the MCOs to identify primary and secondary issues or problems and work with BMS and the MCOs to identify interventions or solutions to overcome the issues detected.

Identifying Best Practices

From its extensive experiences validating PIPs across the country, HSAG can provide BMS and the MCOs with insights and best practices gained from having reviewed a vast number of topics, such as childhood obesity, diabetes care, well-child care, reducing avoidable emergency room visits, coordination of care, access to care, mental health follow-up, utilization measures, seclusion and restraint reduction, prenatal care, consumer satisfaction, and timeliness of care. HSAG will work with BMS and the MCOs to identify and implement best practice interventions that bring about true and sustained improvement in indicator results.

PROVIDING TECHNICAL ASSISTANCE AND ORIENTATION

HSAG is prepared to provide technical assistance to BMS and the MCOs throughout the PIP process.

HSAG's technical assistance focuses on several key areas:

- Providing information to BMS and MCOs regarding the validation process, criteria, and related federal requirements/protocols
- Providing information to BMS and MCOs regarding supporting materials that MCOs should submit to meet validation requirements
- Providing information on industry standard practices for conducting PIPs
- Providing meaningful and timely feedback to MCOs regarding each PIP
- Conducting follow-up conference calls with the MCOs to discuss evaluation results if requested and/or approved by BMS
- Assisting MCOs in determining the possible reasons that PIPs have not achieved improvement and providing recommendations for improvement to BMS and the MCOs
- Identifying best practices, common issues, and performance trends and conveying this information to BMS and the MCOs
- Assisting in educating BMS and the MCOs regarding pertinent performance improvement project study areas

HSAG will conduct an orientation meeting that will prepare BMS and the MCOs for all PIP-related activities. During this meeting, the HSAG PIP Team will present a PIP 101 training; discuss and provide materials on causal/barrier analysis, sub-group analysis, statistical testing, and analysis of results; and discuss the timeline for PIP activities.

HSAG provides technical assistance through e-mails, conference calls, and/or Webinars. With BMS' approval, HSAG may provide Webinars to respond to global questions with answers that would benefit all MCOs.

Additionally, the technical assistance provided by HSAG has enabled health plans to analyze their data, identify appropriate interventions to overcome barriers, and bring about true improvement. Many of HSAG's state clients and participating health plans have provided positive feedback regarding the helpfulness of the HSAG staff, such as:

> ***"The [HSAG staff person] is very knowledgeable…He really tries to focus on areas the entire group needs clarification with."***

Staff/Team Experience and Qualifications

Gretchen Thompson, MBA, CPHQ, is an Executive Director for HSAG's State & Corporate Services Division. Ms. Thompson is responsible for overseeing the Performance Measure

Validation (PMV) and PIP Validation teams. Ms. Thompson has more than 14 years of experience in Medicaid and has worked in a number of different Medicaid delivery systems, such as managed care, fee for service, long term care, physical health, and behavioral health. Ms. Thompson has an extensive background in federal and state health care policy, data systems, and quality assessment and performance improvement. In her current position, Ms. Thompson oversees the development of all project deliverables and is responsible for the quality of all work performed by PIP and PMV staff members, ensuring client satisfaction with the work product provided.

Prior to joining HSAG, Ms. Thompson was President of Pinnacle Strategies, a private health care consulting firm focusing on strategic planning, business development, quality improvement and compliance, Medicaid waiver program development and implementation, and initiatives to improve health care for seniors and people with disabilities. She has also worked for a national managed care organization designing and implementing high-quality cost savings health care programs, and developing new health care program initiatives in Medicaid and other public sector health care programs. At the request of the National Advisory Board on Improving Health Care for Seniors and People with Disabilities, Ms. Thompson authored the community mobilization white paper, *Declaration for Independence: A Call to Transform Health and Long Term Services for Seniors and People with Disabilities*. Ms. Thompson was also a member of the Heinz Family Philanthropies consulting team for projects involving 340B pharmaceutical research and analysis and health care reform.

Ms. Thompson holds a Bachelor of Arts Degree in Psychology from Arizona State University and a Master of Business Administration Degree from the University of Phoenix. She is also a Certified Professional in Health Care Quality (CPHQ) from the Healthcare Quality Certification Board.

Christi Melendez, RN, **CPHQ,** is the Associate Director of Quality Improvement Projects at HSAG and is responsible for leading the plan-specific, small-group, and collaborative PIP validation activities and tasks performed by the HSAG PIP Validation Team. Ms. Melendez has been with the company since 2001. She has more than 20 years of nursing experience in the clinical and home health settings, including case management and medical record reviews. In her current role, she works closely with the PIPs manager to validate health plan performance improvement projects by assessing the implications on the validity and reliability of the PIP findings. Ms. Melendez is responsible for providing technical assistance and training to states, as needed. In addition, she is also an RN abstractor/coordinator, performing review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She has assisted in the training of other RN abstractors and has provided on-site medical reviews for HEDIS auditing.

Ms. Melendez's prior experience includes 14 years of case management of long-term, chronically ill children, maternity and pediatric patients, and home health infusion patients. She was responsible for preparing quality assurance and treatment plans as well as performing medical record/documentation audits. She was actively involved in performance improvement activities.

Ms. Melendez is a Registered Nurse with an Associate of Science Degree in Nursing from Cypress College in California. She recently became a Certified Professional in Healthcare Quality (CPHQ).

Christy Hormann, MSW, CPHQ, is Project Leader and PIP Reviewer at HSAG. Ms. Hormann is responsible for validating plan-specific, small-group, and collaborative PIPs. She has been with HSAG since 2002. In her current role, she performs validation of physical and behavioral health quality improvement projects (QIPs) by assessing the implications on the validity and reliability of the PIP findings based on CMS Protocol. She is responsible for assisting in tool development and report preparation as well as providing technical guidance on how to conduct PIPs to clients, as needed. Prior to moving to her current position, Ms. Hormann was a project coordinator for the State & Corporate Services Division, providing day-to-day oversight and management of data abstraction staff members. She also performed reviews of behavioral health records, including data abstraction on the Arizona Department of Health Services Division of Behavioral Health Services Independent Case Review project from 2002 to 2007. Additionally, Ms. Hormann has completed medical necessity review as well as face-to-face interviews with Title XIX and Title XXI members, under the age of 21, receiving behavioral health services through the State of Arizona.

In the past, Ms. Hormann has been a social worker for a renal dialysis center, performing quarterly chart reviews as well as assessment, referral, and coordination of patient services. She was responsible for the distribution and tracking of annual patient satisfaction surveys for yearly performance measures. Upon completion of the yearly performance measures, she analyzed and implemented performance improvement projects. In addition, she worked as a Child Protective Services specialist for the Arizona Department of Economic Security, performing case management of children and families and utilization review. She also prepared and presented individual cases to the Foster Care Review Board.

Ms. Hormann holds a Bachelor of Science Degree from St. Cloud State University and a Master of Social Work Degree from Arizona State University. She is a Certified Professional in Healthcare Quality (CPHQ) by Healthcare Quality Certification Board.

Don Grostic, MS, is Associate Director, PIP Analytics, at HSAG. Mr. Grostic is responsible for validating plan-specific, small-group, and collaborative PIPs, providing analytical expertise, and performing technical interpretation of PIP findings. He is responsible for validating the scientific soundness of study design as well as the analysis and interpretation of a variety of health care studies, including analysis of CAHPS and other health care surveys. Other studies for which Mr. Grostic provides expertise include those focusing on HEDIS, network adequacy, encounter data validation, quality of care, and the Early and Periodic Screening, Diagnosis, and Treatment program. Mr. Grostic reviews and validates each PIP from an analytic perspective, specifically evaluating the study indicator development, sampling methodology, analysis plan, statistical testing, and accuracy and validity of the results. Mr. Grostic has also provided technical assistance to acute care and long term care health plans to assist in the application of the CMS Protocols for conducting PIPs.

Mr. Grostic holds a Bachelor of Science Degree in Mathematics and a Master of Science Degree

in Biostatistics both from the University of Vermont.

Kate Bell, MA, Certified Paralegal, is PIP Reviewer at HSAG. In this role, Ms. Bell reviews and evaluates plan-specific, small-group, and collaborative PIPs to determine the completeness of the PIP submitted. She has over eight years of experience in the design, implementation, analysis, evaluation, and reporting of health care quality improvement projects. Ms. Bell coordinates and participates in data abstraction, data collection, data comparison and deliverable monitoring. Ms. Bell's legal background compliments her expertise at researching historical documents and reviewing documentation to ensure completeness.

In the past, Ms. Bell has worked for private and public health care organizations with a focus on performance improvement. Her extensive experience with diverse behavioral health populations includes administering and monitoring the member grievance and appeals program. Ms. Bell has co-coordinated a JCAHO reaccreditation process and provided performance improvement training and technical assistance to staff members and providers.

Ms. Bell holds a Bachelor of Arts Degree in Communications from Virginia Tech and a Master of Arts Degree in Organizational Management from the University of Phoenix. She is a Certified Paralegal and holds a certificate in Quality Management from Learning Tree University.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
TTL	Task Team Leader	Gretchen Thompson, MBA, CPHQ
PAD	PIP Associate Director	Christi Melendez, RN, CPHQ
PS	PIP Reviewers	Christy Hormann, MSW, CPHQ Kate Bell, MA
AN	PIP Analyst	Don Grostic, MS
RT	Reports Team	Cheryn Wall, EdD Reports Team Staff
PC	Project Coordinator	Jenny Montano

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Monthly Activities			
Participate in monthly activities that may include conference calls, progress report updates, etc.	OPD, TTL, PAD, PC	4/1/12	3/29/13
CONTRACT YEAR 1 (2012-2013)			
PIP Validation Process Description			
Prepare the written description of the PIP validation process.	PAD, PS, RT, PC	4/2/12	4/13/12
Submit written description of the PIP validation process to BMS.	PAD, PC	4/16/12	4/16/12
Preliminary PIP Documentation Review and Approval			
Develop draft PIP submission letter, PIP Summary Form, PIP Validation Tool, and PIP Validation Report Template	PAD, RT, PC	4/2/12	4/13/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Forward PIP submission letter, PIP Summary Form, PIP Validation Tool, and PIP Validation Report template to BMS for review and approval.	PAD, PC	4/16/12	4/16/12
Receive comments/feedback from BMS and make any necessary revisions.	PAD, PC	4/30/12	4/30/12
Finalize PIP documents	PAD, RT, PC	5/1/12	5/4/12
Technical Assistance			
Technical assistance for PIP completion and progression as directed by BMS (to include conference calls and Webinars).	PAD, PS, AN, PC	5/7/12	Ongoing
Develop PIP training materials.	PAD, PS, RT	5/7/12	5/18/12
Submit PIP training materials to BMS for review.	PAD	5/18/12	5/18/12
Receive feedback from BMS and finalize PIP training materials.	PAD, PS	6/1/12	6/1/12
Conduct MCO/BMS PIP training	PAD, PS, AN	6/4/12	7/27/12
PIP Validation Activities			
Forward PIP submission letter and all supporting PIP documents to MCOs 30 days prior to PIP submission due date.	PC	8/3/12	8/3/12
Receive PIPs from MCOs and log in all submissions.	PC	9/7/12	9/7/12
Assess PIP methodology and evaluate validity and reliability of results and complete validation tool.	PAD, PS, AN	9/10/12	10/31/12
Complete draft PIP Validation Reports.	PAD, PS, RT, AN	10/31/12	11/30/12
Submit draft PIP Validation Reports and Validation Tools to BMS for review.	PAD, PC	12/3/12	12/3/12
Receive BMS feedback on draft reports and tools.	PAC, PC	12/19/12	12/19/12
Incorporate feedback and finalize PIP Validation Reports and PIP Validation Tools.	PAD, PS, AD,RT	12/20/12	1/11/13
Submit Final Reports with validation tools to BMS and MCOs.	PAD	1/18/13	1/18/13

2.4.3 HSAG's Plan to Validate Performance Measures

2.4.3	The Vendor should propose a plan to validate performance measures as required by 42 CFR §438.358(b)(2). The Vendor should propose a plan to validate MCO performance measures reported (as required by the State) or MCO performance measure calculated by the State during the preceding twelve (12) months to comply with requirements set forth in 42 CFR §438.240(b)(2). The plan should describe how the Vendor develops an understanding of State requirements, prepare the MCOs for onsite activities, conduct an assessment or reviewing the results of a prior assessment of the MCOs' information systems, review and assess the MCOs' procedures for collecting and integrating data, evaluate MCO processes to produce performance measures, evaluate the MCOs' processes for State reporting, produce required reports for the State, and conduct any necessary follow-up with the MCOs.

Experience With Similar Projects

Auditing and reporting of performance measures is a core competency of the staff at HSAG. HSAG excels in using acceptable methods of Validation of Performance Measures following CMS Protocols, including HEDIS Compliance Audits. HSAG has been an NCQA-Licensed Organization (LO) to conduct NCQA HEDIS Compliance Audits™ since 1998 and has developed an expertise in applying the validation process to a variety of managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and other health care delivery systems. HSAG is entering its 14th year of performing NCQA HEDIS Compliance Audits™. Over the years, based on its experience performing more than 450 HEDIS Compliance Audits, HSAG has developed a more mature and efficient audit program. It is important to note that HSAG has gained much of its experience by auditing the Medicaid product line of business. HSAG currently performs aspects of performance measure validation activities (including HEDIS Compliance Audits) as part of external quality review in 12 states: California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, Tennessee, Vermont, and Washington.

HSAG has extensive experience across a number of states in validating HEDIS and/or HEDIS-like measures, including measures that target such areas as children's health, pregnancy, long term care utilization, and behavioral health. Given that HSAG has both collected data for and reported HEDIS measures as well as audited MCO rates for performance measures, HSAG's staff is very knowledgeable about data collection challenges and the strengths and weaknesses of certain measures. In addition, knowing the common challenges associated with data collection and reporting, HSAG can provide insight into the interpretation of results for the performance measures.

HSAG has successfully worked with Medicaid MCOs in several states to communicate the specifications for selected measures and to monitor the process of data collection. In some of those instances, there were no existing performance measures targeting the specific quality of care, type of care, or disease that a state had an interest in measuring. HSAG has worked with several states to develop performance measures and objectives that examine such indicators as lead screening in children, EPSDT services, dental sealants in children, quality of prenatal care,

adherence to state-mandated guidelines for mental health services, initial health assessments, and access to care.

HSAG has experience working with states and their health care organizations on reporting rates by various populations, including, Child Health Insurance Program (CHIP), aged, blind, and disabled (ABD), children with special medical needs, Medicare, and dual-eligible members. HSAG's auditors are experienced with processes that ensure populations can be identified and reported appropriately and according to state requirements or measure specifications.

Since 2006, HSAG has participated in a pay-for-performance (P4P) collaborative in California. This statewide initiative was developed by the Integrated Healthcare Association (IHA), a leadership group of California employers, health plans, and physician organizations. It was designed to stimulate significant improvement in patient satisfaction and clinical quality. The P4P program (1) collects a common set of patient satisfaction and clinical performance measures for physician groups; (2) provides significant health plan payments to the groups based on their performance, including significant financial rewards for improvement; and (3) publicly reports performance results through a consolidated scorecard. Since 2006, HSAG has performed over 375 physician organization-level audits for the P4P program following NCQA HEDIS audit guidelines and methodology.

HSAG has developed a compilation of audit tools, tracking forms, interview guides, site visit agendas, source code review sheets, and other working papers relevant to the Medicaid product line that have been used, tested, and improved upon over the years. HSAG has also developed and uses automated rate review and benchmarking tools to give MCOs feedback on submitted rates and performance.

HSAG's overall approach to the validation process is of a collaborative and supportive nature, which is a style that is unique among most other audit organizations. HSAG's auditors and audit team work with each MCO through technical assistance calls and communication to identify issues early on, suggest corrective actions, and evaluate the success of such corrective actions on Medicaid performance measure reporting.

Staff/Team Experience and Qualifications

Gretchen Thompson, MBA, CPHQ, is an Executive Director for HSAG's State & Corporate Services Division. Ms. Thompson is responsible for overseeing the Performance Measure Validation (PMV) and PIP Validation teams. Ms. Thompson has more than 14 years of experience in Medicaid and has worked in a number of different Medicaid delivery systems, such as managed care, fee for service, long term care, physical health, and behavioral health. Ms. Thompson has an extensive background in federal and state health care policy, data systems, and quality assessment and performance improvement. In her current position, Ms. Thompson oversees the development of all project deliverables and is responsible for the quality of all work performed by PIP and PMV staff members, ensuring client satisfaction with the work product provided.

Prior to joining HSAG, Ms. Thompson was President of Pinnacle Strategies, a private health care consulting firm focusing on strategic planning, business development, quality improvement and compliance, Medicaid waiver program development and implementation, and initiatives to improve health care for seniors and people with disabilities. She has also worked for a national managed care organization designing and implementing high-quality cost savings health care programs, and developing new health care program initiatives in Medicaid and other public sector health care programs. At the request of the National Advisory Board on Improving Health Care for Seniors and People with Disabilities, Ms. Thompson authored the community mobilization white paper, *Declaration for Independence: A Call to Transform Health and Long Term Services for Seniors and People with Disabilities*. Ms. Thompson was also a member of the Heinz Family Philanthropies consulting team for projects involving 340B pharmaceutical research and analysis and health care reform.

Ms. Thompson holds a Bachelor of Arts Degree in Psychology from Arizona State University and a Master of Business Administration Degree from the University of Phoenix. She is also a Certified Professional in Health Care Quality (CPHQ) from the Healthcare Quality Certification Board.

Wendy Talbot, MPH, CHCA, is the Associate Director of Audits and is responsible for the oversight and management of HSAG's NCQA HEDIS® Compliance Audit program as well as the Validation of Performance Measures activities for EQRO contracts. Prior to being appointed to her current position, Ms. Talbot served as the Arkansas project manager, overseeing the day-to-day contract activities for HSAG's Arkansas data mining and program evaluation contract. She was also a project manager within the Audit Department, where she was responsible for support of the HEDIS audit program and all performance measure validation activities, including communicating with health plans, preparing agendas and scheduling and conducting site visits, reviewing the systems capabilities tools completed by the health plans, reviewing programming logic and output files, and compiling audit results into final audit reports. Ms. Talbot is an NCQA-Certified HEDIS Compliance Auditor and she is skilled in primary source verification of eligible population and numerator files, ensuring algorithmic compliance, and assessing bias using NCQA and CMS techniques and protocols.

Her previous roles at HSAG included project coordinator for performance improvement projects (PIPs), performing validation of physical and behavioral health PIPs, and participating on external quality review and compliance audits of Michigan mental health plans. She also served as a health care analyst with HSAG's Federal Division, providing analytic support for the CMS 7th Scope of Work quality improvement organization (QIO) contract and analyzing and reporting on ambulatory care and inpatient data, including mammography, diabetes and immunizations.

Ms. Talbot has more than seven years of experience in epidemiology, data analysis and management, and health care/disease program management with state Medicare/Medicaid programs. She holds a Bachelor of Science Degree in Health Sciences from the University of Nevada at Reno and a Master of Public Health Degree from the University of Arizona, with emphasis in epidemiology.

Marilea Rose, RN, BA, is an Associate Director of State and Private Projects for HSAG's State & Corporate Division. She has been with HSAG since October 1997. Her current role includes oversight and management of the various focused studies and encounter data validation studies for several of HSAG's EQRO projects and for physical and behavioral health quality studies for private entities. She is also responsible for the training and ongoing quality oversight of HSAG's RN medical record abstraction team and the medical record HEDIS validation process for several managed care organizations. Ms. Rose works collaboratively with HSAG's Informatics Department to develop data collection instruments and the interrater reliability testing for various studies. In her previous position as Medical record abstractor, Ms. Rose performed reviews of AHCCCS, Arizona's Medicaid agency; HEDIS; and EQRO medical records to determine medical necessity and appropriate level of care. In addition, she performed ad hoc collection of specific data for cooperative projects. Ms. Rose received an Associate Degree in Nursing from Maryville University in St. Louis, Missouri, and a Bachelor of Arts Degree in Management from Ottawa University in Phoenix.

Proposed Approach and Methodology

HSAG understands that it is expected to validate all of the MCOs' reportable HEDIS measures each contract year, including some hybrid measures. HSAG will provide an on-site orientation to the performance measure validation process to both the BMS and the MCOs, which includes a discussion of the role of the auditors, the timeline for the activities, and specifically what the reviews will measure. During this orientation the BMS and the MCOs can request one-on-one technical assistance, if needed.

PROJECT PLAN

HSAG understands it will conduct on-site performance measure validation audits (HEDIS audits) of all selected performance measures for each contracted MCO. HSAG will conduct all HEDIS audits in accordance with the CMS Validation of Performance Measure Protocol (or *HEDIS Compliance Audit Standards, Policies and Procedures,* developed by NCQA). The CMS Validation of Performance Measures Protocol and NCQA's HEDIS Compliance Audit™ process are very similar in terms of methodology and key activities. The main differences are in (1) the NCQA requirements for the type of entity to perform the validation activities; (2) public reporting procedures; and (3) the data collection tool—i.e., CMS Protocol uses the Information Systems Capabilities Assessment Tool (ISCAT) rather than NCQA's Record of Administration, Data Management and Processes (Roadmap) used for HEDIS audits.

A description of major activities performed in each of the validation steps follows.

PRE-ON-SITE

Preparation and Planning

In the validation process, HSAG has found it invaluable to emphasize preparation and planning so deadlines and expectations for deliverables are clearly identified and agreed upon. HSAG uses this planning phase to introduce the team to each MCO via a kickoff conference call and clearly defines the roles and responsibilities of the HSAG validation team, the BMS, and the MCO staff. During this phase, HSAG confirms critical dates for potential meetings with appropriate staff.

HSAG will prepare a request for documentation from each MCO that will include the NCQA Roadmap, the accompanying documentation, and a timeline for completion. The assessment tools have been designed to be clear so that all requests for information can be easily understood. The assessment tools are used to evaluate the effectiveness of the information management system. The tools also cover data integration processes and seek information about the methods used to determine rates for specific measures including:

- Facts about the MCOs' programs, membership and populations (Medicaid, CHIP, etc.), and the health services delivery environment.
- Common data formats accepted by the MCO and/or providers and their administrative or billing services.
- Data file layouts and field descriptions.
- Any historical results of data validation studies addressing the quality (e.g., accuracy and completeness) of data used in reporting.

HSAG's review of the submitted completed assessment tool enables its audit team to prepare for a site visit and to clarify any outstanding issues in advance of the face-to-face meeting.

Assess Integrity of MCO Information Systems (IS) and Performance Measure Programming

HSAG is prepared to assess the structure and integrity of the MCOs' underlying information systems, including their ability to collect valid data from various internal and external sources. This is a critical validation task that provides valuable feedback to the MCOs on the integrity of the IS and the completeness and accuracy of the data produced by that system. As part of the ISCAT or Roadmap request, HSAG receives detailed information regarding all data systems that feed into collection and reporting of performance measures, including membership data, provider data, medical record review processes, claims/encounter data, vendor data (if applicable), and data integration processes.

Specifications and detailed source code for each measure's denominator and numerator, as well as accompanying information, will be reviewed. The audit team will review the documents submitted to identify particular system or procedural weaknesses that may have an impact on the accurate calculation of performance measures. HSAG's programmers, assigned based on familiarity and expertise with the programming language, conduct a detailed review of each line of code. The HSAG source code review teams have three major objectives when reviewing code:

- To assure strict compliance with measure specifications and accuracy of programming logic. Any deviation from specifications is noted and described in detail via feedback in writing. Verbal consultation is provided as well.
- To identify and estimate the potential for bias introduced to the measure calculation by each deviation, as well as the magnitude of error. For example, errors may result in underestimated or overestimated rates, or an issue may result in minimal or no impact on the final rate.
- To identify issues requiring corrections to code or further investigation. Each issue will be

clearly documented and discussed with MCO staff members (if applicable), with agreement on action steps.

HSAG auditors typically review the assessment tool documentation and programming logic, or source code, off-site in HSAG's offices in order to assure efficiencies, be less intrusive, and achieve time economies for the entire project. HSAG attempts to identify all issues requiring action before the on-site visit, so specific strategies can be discussed while on site or the time can be used to verify corrective actions. After all code corrections are verified by the validation team, HSAG provides a final, written summary to each MCO of the programming review process, findings, and implications for measure designations. Source code review is not required for plans that contract with an NCQA-certified software vendor. In these instances, HSAG requires the MCO to submit the certification report indicating the vendor is certified to report the HEDIS measure set for the reporting year. In the event a vendor does not achieve certification for a particular measure, the MCO will be required to submit source code. For all non-HEDIS or state-developed measures, the MCOs will be required to submit source code to HSAG for review.

ON-SITE REVIEW ACTIVITIES

Introductory Session

Once on-site, the HSAG team meets with the key staff involved in the data collection and reporting processes. During the introductory session, the HSAG team members introduce themselves and explain how they will proceed with the review. They reiterate the purpose of the review, the scope of the work, the documentation that is required, and the queries HSAG will perform. Also during this session, the MCO gives the auditors an overview of its organization, changes from previous years, and addresses any areas of concerns or questions to be discussed during the on-site review. The agenda is reviewed to ensure the appropriate staff members will be available for each session.

Data Integration and Documentation Review

HSAG will assess the procedures the MCO has in place for collecting and integrating medical, member, and provider information covering both clinical and service-related data, from internal and external data sources. The goal of this session is to determine how data sources are combined and how the analytic file is produced for reporting of the selected performance measures. Backup documentation on data integration are reviewed. The HSAG team interviews the staff regarding software products used during data file production, sampling, and measure computation. HSAG's team also review the MCO's data control and security procedures during this session

Also at this session, the HSAG team discusses the MCO's documentation processes used for collecting, storing, validating, and reporting the performance measure data. This session is designed to be interactive with key MCO staff members so the review team can get a complete picture of all steps taken to generate the performance measures. This interview process is used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice. The team takes notes during the interviews and documents review findings in the audit working papers. Types of documentation reviewed include the project work plan, data files, data dictionaries,

system edit and validation checks, testing and validation of output files, computer queries, policies and procedures, log files, and database/application manuals.

Algorithmic Compliance Evaluation

HSAG will evaluate processes used by the MCOs to produce performance measures, such as sampling and calculation of denominators and numerators. The on-site audit consists of a rigorous information systems assessment, focusing on claims and encounter data processing, membership data, and provider data. Additionally, the review evaluates the processes used to collect and calculate the measures, including accurate numerator and denominator identification, sampling, and algorithmic compliance (i.e., rate calculations are performed correctly, medical record and administrative data are combined appropriately, numerator events are counted accurately, and populations are identified correctly for population-level reporting).

Primary Source Verification

HSAG will evaluate the MCOs' ability to integrate different types of information from multiple data sources into a data repository or set of consolidated files for use in constructing the performance measures. HSAG uses several techniques, including interviewing, primary source verification, documentation review of processes and systems, and observation to examine the data collection and reporting processes to cover these topics:

- Live demonstration of the claims and encounter processing systems and procedures, from point of receipt in the mailroom/server through posting for payment.
- Review of the provider files and enrollment/eligibility processing system.
- Data extraction from systems used to house production files and generate reports, including a potential review of data included in the samples for the selected measures.
- Discussion with programmers regarding the source code review component of the audit.

Primary source verification at the member level is performed to determine the accuracy of data. This process involves finding members reported in each measure calculated by each MCO. The member's eligibility information and claims history is then verified and compared to the calculated results by tracing to the original "source data" that qualified the member for the denominator and numerator event and confirming the "hit" with the measure specifications for qualify diagnosis and/or procedures codes.

Summation Conference

At the conclusion of the on-site visit, the HSAG team conducts a summation conference with key MCO staff members. The intent of this meeting is to summarize preliminary findings, outline the documentation requirements for any post-visit activities, and determine the next steps in the audit process.

POST-ON-SITE ACTIVITIES

Medical Record Review Validation

Selected performance measures may be collected using the hybrid method (both administrative data and medical record data) or solely from medical record review. To validate the reliability and accuracy of data collected by medical record review, HSAG uses a series of key steps, which have been refined and improved as HSAG has used them over the years in numerous medical record validation activities. The HSAG HEDIS medical record review director and team reviews the MCO's medical record review and record procurement process, including supervisor and staff qualifications for medical record reviews, training of reviewers, hybrid abstraction tools, and quality assurance testing of review results. In addition, to ensure the plan is accurately abstracting the medical record data, the auditor may require the MCO to undergo a convenience sample early in the record procurement and abstraction process. A convenience sample involves the HSAG review team conducting a review of a few selected numerator-positive or negative cases across the various HEDIS measures. Upon conclusion of the review, the HSAG team will provide feedback based on the measure-specific NCQA specifications.

Medical record review validation concludes with an over-read of the MCO's abstracted data. In accordance with NCQA standards, in order to assure reliability and validity of the data collected, the HSAG medical record review team performs an over-read of a minimum random sample of 30 medical records for each of two reported measures. The medical records for over-read are supplied by the MCO, based on written instructions provided by HSAG. The over-read verifies the accuracy and level of compliance in the MCO's medical record abstraction process by comparing HSAG's re-review findings with completed reviews and medical records provided by the MCO's staff.

HSAG staffs all efforts with experienced medical record review professionals who are well-versed with the HEDIS specifications and with any state reporting requirements. In addition, any HSAG audit team member who handles or reviews medical records adheres to strict rules of conduct to preserve the confidentiality of medical information and complies with all applicable HIPAA guidelines.

HSAG adheres to all of NCQA's medical record review requirements and timelines.

Follow-up Information and Corrective Actions Evaluated

HSAG will notify each MCO of all findings within two weeks (10 business days) to allow enough time to implement improvements. HSAG will provide a detailed worksheet of identified issues or concerns by measure, an estimate of the effect of the error on the measure's rate, and recommended remedial activities. It is HSAG's experience that not every issue or problem requires adjustment—only those that have a material impact on reporting rates.

HSAG then uses the worksheet to track the back-and-forth verbal and written exchange of information throughout the corrective action and reverification process. HSAG ensures that each issue is resolved, along with the dates of correction and verification. HSAG provides the MCO staff with verbal and written summaries of opportunities for improvement.

HSAG's validation team has been instrumental in assisting MCOs and state agencies with identifying ways to enhance data completeness to ensure the highest rates attainable. For

example, on numerous occasions HSAG has identified the potential for data loss at the MCO and has provided recommendations on how to mitigate the problem. HSAG also has a strong reputation in assisting MCOs to comply with state agency specifications.

Over the years, HSAG's validation team has assisted several states and health plans with implementing corrective action plans when performance measure specifications were not met or followed. HSAG provided technical assistance to these MCOs throughout the corrective action phase, which eventually enabled the MCOs to become compliant with individual state specifications. Ongoing technical assistance and support is available to the MCOs year-round if requested or as needed—, especially during the HEDIS season—for any potential identified issues.

Report of Final Audit Findings to NCQA

After the NCQA HEDIS Compliance Audit™ is performed, audited rates are submitted to NCQA via NCQA's Interactive Data Submission System (IDSS). In addition, audited rates are used as one of the components for calculating accreditation scores for those MCOs that seek NCQA accreditation. Audited data on MCO performance may be publicly reported in MCO, state, or national reports.

ISSUE REPORT OF FINAL AUDIT FINDINGS TO BMS AND THE MCOS

HSAG will produce, for BMS and each MCO, a Final Audit Report that presents the overall findings of the audit, all corrective actions recommended and corrective actions carried out successfully by the MCO, and the resulting audited rates for each of the performance measures. Noncompliance with NCQA's Information System Standards, as well as any unsuccessful corrective actions, will be explored in detail and any impact on final reported results or HEDIS reporting capabilities will be clearly identified. The Final Audit Report will build upon the earlier report of preliminary audit findings, and will include:

- Updated text and findings based on BMS comments and reactions to the initial report.
- Results of any re-review of corrected programming logic.
- Final results of the medical record validation process.
- Any corrections made to data samples used for final measure calculation.
- Final auditor's opinion, which can be submitted to external parties.
- The auditor-locked NCQA IDSS results with completed Audit Designation Table.
- For non-HEDIS measures not reported in the IDSS, reporting templates that include the audited rates and designation findings.

HSAG is prepared to produce Final Audit Reports for three MCOs. HSAG understands that the Final Audit Report should reflect the audit findings concerning the entire MCO's information systems and HEDIS data collection and reporting capabilities.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD	West Virginia Project Lead	Debbie Chotkevys, DHA, MBA
PMVD	Executive Director, State & Corporate Services	Gretchen Thompson, MBA, CPHQ
ADA	Associate Director, Audits	Wendy Talbot, MPH, CHCA
PC	Project Coordinator	Tammy Gianfrancisco
MRS	Medical Record Supervisor	Marilea Rose, RN
MRPC	Medical Record Project Coordinator	Maricris Kueny
MRR	Medical Record Reviewers	Clinical Nursing Staff
A	Auditors	Assigned from team consisting of: Wendy Talbot, MPH, CHCA David Mabb, MS, CHCA Jennifer Lenz, MPH, CHCA Thomas Cross, MBA Joseph Tenison, MBA
SCR	Source Code Reviewers	Analytic/Data Programming staff

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Contract Start-up	OPD, WVPD, PMVD, ADA	4/2/12	
Pre-Onsite Phase			
Preparation for auditing and reporting performance measures	ADA	4/2/12	5/1/12
Work with BMS to determine measures to be validated	OPD, ADA	4/2/12	7/2/12
Draft MCO introductory Roadmap/ISCAT request letter and attachments	ADA	7/2/12	7/13/12
Submit Roadmap/ISCAT request letter and attachments to BMS for review and approval	ADA, PC	7/16/12	7/16/12
Receive BMS feedback and approval on Roadmap/ISCAT request letter and attachments	ADA, PC	7/16/12	7/27/12
Mail Roadmap/ISCAT request letter and attachments to MCOs	PC	8/1/12	8/1/12
Receive completed Roadmap/ISCATs and source code from MCOs	PC	9/7/12	9/7/12
Review submitted Roadmap/ISCAT and provide feedback to MCOs	A, PC	9/10/12	9/21/12
Review source code submitted by MCOs and provide feedback reports and approval	A, PC, SCR	9/10/12	10/19/12
Onsite			
Conduct an on-site review of MCOs' information systems capabilities, interview key staff members, review performance measure calculation processes, and conduct primary source verification	A	9/24/12	10/5/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Post-Onsite Phase			
Produce and deliver initial report of finding (10 business days after on-site visit)	A, PC	10/8/12	10/19/12
Preliminary rate review	A	10/8/12	10/31/12
Follow up on documents requested during on-site and outstanding issues	A, PC	10/5/12	10/31/12
Medical Record Review Validation			
Select two hybrid measures for validation	MRS, A	9/24/12	10/31/12
Notify MCO of selected measures and request numerator-positive list	MRPC	9/24/12	10/31/12
Receive numerator-positive lists for selected measures	MRPC	9/24/12	10/31/12
Selects sample validation cases from numerator-positive list	MRS	9/24/12	10/31/12
Send medical record request for sample cases	MRPC	9/24/12	10/31/12
Receive medical records and completed abstracts from MCOs	MRPC	9/24/12	10/31/12
Review medical records and calculate results	MRS, MRR	9/24/12	10/31/12
Notify MCOs of medical record validation results	MRS, MRPC	11/1/12	11/2/12
Data Review			
Auditor performs final data file review	ADA, A	11/5/12	11/16/12
Final Reports			
Auditor finalizes information systems findings and outstanding follow-up items	A, PC	11/5/12	11/16/12
Submit draft MCO-specific reports to BMS	PC	11/16/12	11/16/12
Receive feedback from BMS on reports	BMS	11/19/12	12/7/12
Finalize MCO-specific reports	A, PC	12/10/12	12/14/12
Submit final MCO-specific reports to MCOs and BMS	PC	12/17/12	12/17/12

2.4.4 HSAG's Plan to Conduct an Annual Compliance Review

2.4.4 The Vendor should propose a plan to conduct an annual compliance review as required by 42 CFR §438.358(b)(3) and determine the MCOs' compliance with the standards established by the State to comply with the requirements of 42 CFR §438.204(g), as well as other components of the MHT MCO contract. The plan should address how the Vendor identifies areas to review, in accordance with Federal and State requirements, obtain background information, review documents, conduct interviews, collect any other necessary information, analyze and compile findings, and report results to the Bureau.

Experience With Similar Projects

In its role as the contracted EQRO for numerous state Medicaid agencies, HSAG has conducted compliance reviews of hundreds of Medicaid managed care organizations and is the current EQRO for 14 states. HSAG has expertise and broad experience in (1) reviewing and evaluating the sufficiency of managed care organizations' performance in complying with federal and applicable state regulations and the Medicaid agency's contract requirements related to access, structure and operation, and measurement and improvement standards; and (2) preparing substantive and meaningful reports of its findings and recommendations to improve the managed care organizations' performance in providing services to beneficiaries.

While varying by state, HSAG's EQRO contracts have required it to conduct CMS' required and optional activities and frequently additional state-specified reviews and technical assistance across multiple managed care organizations (MCOs); prepaid inpatient health plans (PIHPs), including behavioral health PIHPs; primary care case management programs (PCCMs); accountable care organizations (ACOs); and other state-specific organizational structures.

HSAG will bring to its BMS review activities a comprehensive and seasoned understanding of the federal Medicaid managed care regulations and their applicability to BMS and its contracted MCOs. This knowledge ensures that the HSAG staff will:

- Conduct efficient and CMS Protocol-compliant review activities.
- Based on the review of documents and MCO staff interviews, arrive at and document accurate, meaningful, and clear findings related to the MCOs' performance.
- Document any required corrective actions for all areas of performance evaluated as not in full compliance.
- Provide meaningful targeted technical assistance to BMS and the MCOs before, during, and after the reviews.
- Identify and provide guidance to BMS related to resolving any conflicts HSAG identified between the federal requirements and the State's contract requirements for the MCOs and/or any applicable federal regulations that were not carried forward into the contracts.

In addition, a number of the HSAG staff members, including those who provide leadership to and conduct MCO compliance reviews, have extensive experience in senior management positions with state Medicaid agencies and managed care organizations. The staff brings to the EQR activities first-hand knowledge and experience in designing and implementing Medicaid state plans, as well as knowledge and experience with quality strategies, programs, processes, accountabilities, MCO and PIHP contract requirements, and compliance reviews. The staff has an in-depth understanding and appreciation of the unique challenges involved in ensuring compliance at all levels of a Medicaid program (the state agency, subcontracted MCOs/PIHPs, direct service providers, delegates, and others).

HSAG's extensive EQRO experience preparing for and conducting compliance reviews for multiple states has also provided it with the opportunity to assess and compare the completeness, quality, and sufficiency of:

- State Medicaid agencies' quality strategies and MCO contract requirements.
- Numerous MCO quality assessment and improvement plans to drive continual quality improvement in performance.

Based on the results of its reviews, HSAG regularly consults with and provides guidance to its state clients and their contracted MCOs in developing new or evaluating the sufficiency of their current quality strategies, policies/procedures and CMO contract requirements, and provides recommendations to strengthen them.

HSAG staff members conducting the compliance reviews are highly skilled, thorough, polished, and professional in conducting the reviews and in evaluating performance based on the documentation and information provided through the interviews.

HSAG has also provided numerous training/orientation sessions for the state Medicaid agencies and their contracted MCOs and has received consistent and positive feedback as to the sessions' effectiveness and value in:

- Previewing compliance review activities.
- Describing the actions and documentation required of the MCOs.
- Preparing the organizations for each step of the process (e.g., HSAG's request for MCO documentation for desk review and MCO on-site review), and the process and timelines for preparing and delivering a draft and final report of findings and recommendations.

HSAG has received consistently positive feedback from the state Medicaid agencies and their MCOs about its approach to, and processes for, conducting the reviews and reporting the findings consistent with the CMS Protocol. In addition, the feedback has included the fact that HSAG is collaborative, well organized, and effective in ensuring that it has complete and accurate information about the MCOs' performance; that HSAG has a professional staff and review processes; and that HSAG provides accuracy, quality, and value in its review findings. An example of this feedback about HSAG's compliance review process follows:

A representative from a CMS Regional Office observing one of HSAG's compliance on-site interviews stated that she had been doing audits for many years but that she had learned so much by observing HSAG's style of interviews… how HSAG clearly had command of the subject matter, put the MCO/PIHP staff at ease, and were very professional in our responses, follow-up questions, and explanations to the staff. She also remarked about how well-prepared HSAG was for each of the reviews and that it was clear that a lot of planning and pre-review had taken place.

Through its extensive work with its EQRO-contracted Medicaid state agencies and their managed care plans, HSAG has demonstrated that it has the experience and expertise required to effectively and proactively collaborate and consult with BMS and with its contracted MCOs in:

- Interpreting federal regulations/requirements for Medicaid agencies and their contracted MCOs.
- Understanding the documentation, actions, and performance results required to demonstrate compliance with those regulations/requirements.
- Providing an overview of HSAG's compliance review activities.
- Effectively and efficiently conducting the compliance review activities and preparing and delivering the MCO-specific reports of findings and recommendations.

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is the Executive Director, State & Corporate Services for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debbie Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work and contract deliverables, and she is the primary contact for state Medicaid agencies relating to the behavioral health scope of work. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement

Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, MBA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which she reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCO performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Prior to joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Diane Christensen, MC, LPC, is a Director, EQRO Services, with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for designated division projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral healthcare settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid-enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Master of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Barbara McConnell, MBA, OTR, is the Project Director for the State & Corporate Services Division at HSAG. She is responsible for analyzing and evaluating pertinent information for physical and behavioral health organization on-site reviews, and coordinating various contract activities and deliverables. Ms. McConnell is responsible for reviewing desk audit materials, on-site audit activities, and the preparation of the report of audit findings for HSAG's Colorado physical and behavioral health EQRO contract. She also participates as part of the compliance team for on-site medical record reviews in multiple other states, including review of organizational standards and compliance, assisting the project team with accurate and supportive recommendations, and providing client feedback and reports on review findings in follow-up to site visits.

Ms. McConnell is a registered occupational therapist with over 20 years of experience in variety of health care settings, including mental health centers, hospitals, and rehabilitation centers. She also brings a thorough knowledge of the start-up and ongoing management of rehabilitative facilities, from development of collaboratives in the community, working with funding sources such as Medicare and Medicaid, and coordinating care plan programs to ongoing case management and quality improvement/assurance.

Ms. McConnell holds a Bachelor of Science Degree in Occupational Therapy from Ohio State University and a Master of Business Administration Degree from the University of Kansas.

Proposed Approach and Methodology

HSAG understands that the overall goal for the EQRO is to review the MCOs' performance in providing care and services to Medicaid managed care beneficiaries, specifically to (1) determine whether the care and services conform to the Medicaid managed care regulations, BMS contract requirements, and professionally accepted standards for quality, access, and timeliness; and (2) assist BMS and the MCOs in designing improvement interventions to address less than fully compliant performance and any identified opportunities for improvement.

HSAG will conduct the review of BMS's contracted MCOs following CMS' February 11, 2003, *Final Protocol, Version 1.0—Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations* to determine the MCOs' compliance with the contract standards established by BMS to comply with the requirements of 42 CFR 438.204(g), as well as other components of BMS' contract with the MCOs. The evaluation of each MCO's performance will include (1) a review of documentation, and (2) interviews with key MCO staff members.

Consistent with the protocols, specific review and evaluation activities will include the following:

- Planning for the compliance review activity.
- Obtaining background information from BMS.
- Reviewing BMS' and the MCOs' documentation.
- Conducting interviews.
- Collecting any other related information.
- Compiling and analyzing findings and reporting results to BMS and the MCOs.
- Identifying any issues or problems regarding access, quality, timeliness, and utilization.
- Verifying the MCOs' compliance with program, systems, and clinical requirements as described in their contract with BMS.
- For each MCO, preparing and submitting to BMS and the MCO a comprehensive report documenting HSAG's findings and recommendations for improvement.
- HSAG will prepare BMS and the MCOs for the review activities that will take place during the EQRO contract year, including an on-site orientation with the MCOs and BMS.

Following are specific steps HSAG will take in performing the compliance review activities:

Conduct Initial Discussions with BMS

HSAG recognizes that before it initiates any of the activities related to the annual compliance reviews, a critical step is to conduct discussions with BMS. This will help HSAG to clarify and reach agreements related to BMS' expectations and requirements for the review activities, the key documents HSAG will use, and the required deliverables. HSAG will work collaboratively with BMS in preparing for, conducting, and reporting findings from its reviews of the MCOs'

compliance with the federal regulations, BMS/MCO contract requirements, and BMS's quality strategy.

OBTAIN BACKGROUND INFORMATION

HSAG understands that each state's Medicaid program is unique in the needs, key drivers, and resources available that define a state's choices in designing and implementing the delivery model. To competently, effectively, and efficiently conduct the EQR compliance review activity and produce reports that provide meaningful, contextual, and accurate findings and recommendations for each state, HSAG must:

- Be informed about the key aspects of a state's Medicaid managed care model, programs, covered services, and its contracted managed care organizations.
- Use this knowledge in preparing for and conducting EQR activities and for reporting its findings.

HSAG's extensive EQRO experience preparing for and conducting compliance reviews and preparing reports of findings for multiple states has provided it with the opportunity to assess and compare the completeness, quality, and sufficiency of:

- State Medicaid agencies' quality strategies and MCO contract requirements.
- Numerous MCO quality assessment and improvement plans to drive continual quality improvement in performance.

HSAG regularly consults with and provides guidance to its state Medicaid agency clients and their contracted MCOs concerning the sufficiency of their plans, policies, processes, contracts, and actions and offers focused state-specific recommendations to strengthen them.

Prior to discussions with BMS, HSAG will request key documents, including:

- The State' Quality Strategy
- Any State laws/statutes, BMS rules, and policies/procedures that impact the MCO contract and performance requirements (e.g., grievance, appeal, and State fair hearing processes; requirements for confidentiality, fraud and abuse, and enrollment/disenrollment).
- BMS's contract(s) with the MCOs.
- The criteria (i.e., the compliance review tool) used to assess the MCOs' performance during the previous year's EQRO review Any BMS-required corrective actions for the MCOs that are still pending from the previous year's compliance reviews.
- Other documents and information BMS identifies as valuable to ensure HSAG has a complete and current understanding of the Medicaid managed care program, past MCO performance strengths and areas requiring improvement, and BMS's goals and priorities for quality improvement

HSAG will also discuss with BMS the relevance and impact of any funding issues, legislative mandates and new initiatives, public policy concerns, and stakeholder influence. Additionally,

HSAG will review other documentation BMS identifies as critical to ensuring that HSAG is fully informed about BMS' obligations and constraints.

Discuss and Reach Agreements With BMS on the Scope of the Review

For each EQRO contract year, HSAG will work with BMS to determine the scope of HSAG's compliance reviews. The reviews will assess each MCO's performance in complying with the federal Medicaid managed care regulations described at 42 CFR 438 and as presented in the State's Quality Strategy and BMS contract requirements with the MCOs. HSAG understands BMS requires a full EQR of compliance for each MCO every year.

To avoid duplication, HSAG and BMS may agree on a method to ensure that the requirements HSAG will review will not duplicate any that can be "deemed compliant" under a review by Medicare or a national accrediting organization.

Prepare BMS and the MCOs for HSAG's Compliance Review Activities

While HSAG's compliance reviews will be conducted consistent with the CMS Protocols, HSAG will also work with BMS to customize its approach to meet the State's needs and preferences. Once these decisions have been reached and prior to initiating the compliance review activities, HSAG will prepare an orientation session for BMS and the MCOs and provide an on-site overview of the compliance review activities at a date and time that is convenient for BMS and the MCOs.

Conduct the Compliance Review Activities

In conducting the review activities and reporting its findings and improvement recommendations, HSAG will apply its knowledge of:

- The federal Medicaid managed care requirements and CMS Protocol for conducting compliance reviews.
- The key BMS and MCO documents.
- Lessons learned from other states and published guidance from CMS and nationally recognized bodies related to improving the quality, timeliness, and access to care and services provided to Medicaid beneficiaries.

Develop Review Tools and the Report Template

- Draft and Finalize the Compliance Review Tool(s):

  HSAG has designed multiple compliance review tools to use with its EQRO contractors. These include tools to review MCOs' performance in complying with State-specified standards and federal Medicaid managed care regulations, and record review tools to evaluate actual practice and processes of the MCO (e.g., enrollee grievances and appeals, service authorization and denials, provider credentialing). These tools have proven highly effective in capturing data on performance in all compliance areas that a state has specified for review. HSAG will use similar performance review tools customized to reflect the standards and requirements in the MCO contract for each year of HSAG's compliance

review activities. HSAG will prepare and submit the proposed compliance review tool(s) to BMS for review, comment, and final approval.

HSAG will also prepare customized MCO on-site visit agendas; on-site document review lists; and other supportive working papers that it has used, tested, and improved over the years of performing compliance review activities.

- Draft and Finalize the Template for the Narrative Summary Report of Reviewer Findings

  In order for HSAG to fulfill its commitment that its deliverables meet BMS expectations for the format, structure/organization, and contents, HSAG will draft and submit to BMS for review and comment a proposed outline and template for the compliance review narrative summary reports of findings. These MCO-specific reports will address HSAG's review findings, including MCO strengths and opportunities for improvement. Based on the findings, the reports will also address any actions required to bring the MCOs' performance into compliance with the requirements and to improve the quality, timeliness, and access to care and services they provide.

Establish the Schedule for the Compliance Review Activities

HSAG is sensitive to the time involved in the MCOs' preparation and participation in the EQR reviews, and that they have additional accreditation and licensing reviews, priorities, and responsibilities as an MCO. Planning and coordination begins, therefore, well in advance of any on-site activity. HSAG will coordinate with BMS and the MCOs to establish the schedule for HSAG's desk- and on-site review activities. This will ensure that key MCO staff members are available for the on-site reviews, and that HSAG's report of findings are provided to BMS and the MCOs within the BMS-approved timeline.

Conduct Pre-on-site Review Activities

Prior to the on-site portion of the compliance reviews, HSAG will identify the information and documentation for both the desk and on-site review activities. To ensure that the MCOs are fully informed about HSAG's process and what is expected from them, HSAG will prepare materials for the MCOs explaining HSAG's review process and activities, the documentation that will be requested prior to the on-site review, additional documentation to have available during the on-site review, and all related timelines for the activities. HSAG will provide these instructions to all three MCOs simultaneously approximately 60 days prior to the first scheduled MCO on-site review.

The instructions will include a cover letter that summarizes HSAG's processes and key dates for all activities and documents requested, and a *Desk Review Form* to complete with information about their organizational structure and processes that HSAG will review. The instruction packet will also include the compliance review tool, which the MCOs will use to list the evidence documents they are submitting for the desk review, as well as any lists of files/records that will be sampled by HSAG for review on site.

The *Desk Review Form* will include detailed instructions for the MCOs for:

- Listing the documents they will provide to HSAG for desk review. HSAG will ask the MCOs

to identify, for each requirement in the compliance review tool, the documentation they are submitting to demonstrate compliance with the requirement.

- Organizing, preparing, and submitting the documents. HSAG will establish a secure file transfer protocol (FTP) site for BMS and the MCOs to use in providing documentation to HSAG. This has proven to be highly effective and efficient and is the method that most of HSAG's EQRO-contracted state Medicaid agencies and their MCOs prefer for transmitting information and documents. This secure site also ensures compliance with Health Insurance Portability and Accountability Act (HIPAA) rules. HSAG will request that, to the extent feasible, BMS and the MCOs use the FTP site to upload all requested documents.

- HSAG will request that the MCOs submit their documents to HSAG for its desk review approximately 45 days prior to the first scheduled MCO on-site review date, ensuring that each MCO has the same amount of time to prepare and provide its documentation to HSAG.

Schedule and Conduct a Pre-on-site Conference Call with the MCOs and BMS

- In addition to conducting an on-site orientation for BMS and the MCOs before initiating the review activities, HSAG will also offer to schedule a conference call with key MCO staff members after sending the letter and instructions related to HSAG's desk review to again preview HSAG's compliance review activities, schedule, and documentation required from the MCOs. This call will provide the MCOs the opportunity to request clarification and present questions concerning the documentation required from them and any other logistical issues needing to be resolved for the review process. It is HSAG's experience that early and frequent communication with the MCOs and the state Medicaid agency is a key step in planning for an efficient and effective desk review, and is a crucial step in arranging and conducting the on-site review.

Conduct a Desk Review of the MCOs Documents

- HSAG's assessment of the MCOs' compliance will begin at the time it receives their completed desk review form and accompanying documentation. HSAG reviewers will use the information to review and update their knowledge of the MCOs' operations, and to ensure that the reviewers are informed about key and current aspects of the MCOs' structure and operations. In reviewing and analyzing the information the MCOs submit, HSAG reviewers will use the review tool to document their preliminary findings; i.e., observations and notes that will assist them in determining the MCOs' compliance with the regulatory provisions and support the completion of the review tool following the on-site review activities. The HSAG reviewers will also identify areas or issues that will require clarification or follow-up during the on-site interviews.

Conduct On-Site MCO Reviews

HSAG anticipates that the review team will take up to three days to conduct the on-site portion of the annual compliance review.

Conduct On-Site Review of Documents and MCO Interviews

HSAG values a positive and interactive working relationship with the MCOs it evaluates, with the goal of creating a learning environment while conducting the EQR activities, including the on-site interviews. HSAG's interviews and other communications with the MCOs will ensure that the MCOs have every opportunity to provide HSAG with the relevant documentation and information demonstrating their performance in complying with the standards. HSAG will request that the MCOs have the appropriate key staff members available for each of the scheduled interviews and for any additional questions or document requests during the review. In addition, HSAG reviewers may ask the staff to demonstrate the MCOs' information system capabilities for collecting, analyzing, and reporting data for key performance processes, such as service authorizations and customer service calls.

HSAG's review team will conduct interviews with the MCOs' staff at the office location of each MCO to:

- Obtain a clear and complete assessment of the organization's compliance with regulatory requirements.
- Answer any questions HSAG has following its desk review of documents, and explore any issues not fully addressed in the documents it reviewed.
- Compare information described in documentation to the information the MCO staff provided during the interviews.
- Provide HSAG reviewers an opportunity to identify and request additional relevant documents that the MCO staff referenced during the interviews but were not provided for review.
- Provide the MCO an opportunity to describe (1) the challenges it experienced in complying with the standards, and (2) improvement actions planned or implemented.
- Encourage MCO staff members to describe what they consider to be innovative and effective approaches for improving processes and efficiencies, enhancing reporting capabilities and the meaningfulness of data and reports produced, and importantly, improving the quality, timeliness, and access to care and services for its beneficiaries. HSAG may assess the MCO approaches as emerging or best practices and areas of considerable strength, and commend the MCO for its proactive and effective activities and the outcomes obtained from them.

Conduct an Exit Conference

HSAG will conduct an exit conference to discuss its preliminary findings related to the assessment of the MCO's strengths and any areas of anticipated findings of noncompliance. For areas of partial or noncompliance HSAG reviewers will identify the areas that need improvement and the actions required to bring the MCO's performance into compliance with the requirements, including specific examples that have been effective and used by other state's MCOs. HSAG reviewers are skilled and trained in describing in a nonthreatening way the areas needing improvement.

COLLECT OTHER RELEVANT INFORMATION

HSAG will also evaluate and analyze additional information from BMS that it could not collect through interviews with the MCO's staff and a review of its documentation. Sources for additional information could include results of activities BMS administered (e.g., beneficiary and provider surveys).

ANALYZE AND COMPILE FINDINGS

Review Information and Documentation using the Compliance Review Tool

HSAG's process for collecting data and evaluating MCO compliance with state contract requirements/standards is manual and reviewers obtain and review documents and information through the MCO staff interviews, documenting their findings using the compliance review tool.

Calculate the Individual Ratings and Determine the MCO's Overall Scores

HSAG reviewers will document their findings for each indicator/regulatory requirement in HSAG's compliance review tool and determine a compliance score. Based on an assessment of the MCO's documentation and interview information, HSAG proposes to use a scoring methodology with compliance designations of *Met*, *Partially Met*, or *Not Met.* When a requirement is not applicable to the MCO for the period covered by HSAG's review, HSAG will use a *Not Applicable* (*NA*) scoring designation. This scoring methodology is consistent with CMS's Final Protocol. The designations are described as follows:

- ***Met*** indicates full compliance, defined as both of the following:
  - All documentation listed under a regulatory provision, or component thereof, must be present.
  - The staff is able to provide responses to reviewers that are consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance, defined as:
  - There is compliance with all documentation requirements, but the staff is unable to consistently articulate processes during interviews; or
  - The staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance, defined as:
  - No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions; or
  - For those provisions with multiple components, key components of the provision could be identified, and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance, regardless of the findings noted for remaining components.

In addition to scoring each individual requirement, HSAG will also calculate a percentage of compliance score for each standard (i.e., a set of related indicators/regulatory requirements), and the MCOs' overall performance across all standards. In calculating a percentage of compliance

score for performance, HSAG typically uses a weighted score. The weighted score is calculated by:

- Assigning a value of 1.0 to each *Met* score, a value of 0.5 to each *Partially Met* score, and a value of 0.0 for each *Not Met* score and NA designation.
- Adding the results for the weighted *Met* scores with those for the weighted *Partially Met* scores.
- Dividing the total summed weighted score by the number of applicable elements.

The following table illustrates the above methodology:

Standard––Availability of Services Results						
Met	=	7	X	1.00	=	7.0
Partially Met	=	3	X	.50	=	1.5
Not Met	=	2	X	.00	=	0.0
Not Applicable	=	3	NA			*NA*
Total Applicable	=	12	**Total Score**		=	8.5
Total Score Divided by Total Applicable					=	71%

HSAG is diligent in the quality control processes it uses to ensure that reviewers are accurate and consistent when they determine and document their findings and scores for each requirement, and when they calculate overall scores for each standard and the score across the standards. The review team leaders will ensure that team members completely and accurately document their findings and that the findings support the scores they assign for each requirement. Team leaders will also consult with each other to ensure that the team members have been consistent in their processes, findings, and scores across the teams and MCOs. HSAG's professional editors will provide an additional check for completeness, accuracy, and consistency of findings and scores.

Prepare the Individual Reports of Results for BMS and Each MCO

At the completion of the compliance review, HSAG will (1) prepare a draft narrative summary report of the findings and recommendations for each MCO; and (2) submit the drafts to BMS and the applicable MCO for review and comment on the accuracy of HSAG's findings. HSAG will review BMS's comments on the draft reports and, as applicable, those from the MCOs. In consultation with BMS, HSAG will make any needed revisions and issue the final reports for each contract year to BMS and the MCOs for their records and for the MCOs to use in preparing their required corrective action plans.

To produce professional, accurate, complete, and meaningful reports and other EQRO contract deliverables and to ensure the highest quality of analyses and results specific to the compliance review reports, HSAG's reports will undergo a strict and sequential internal quality review process and will then be submitted to technical editors and writers who will ensure that the formatting and narrative portions meet the highest professional standards for business writing, formatting, and presentation of the evaluation findings and data.

For each contract year, HSAG will prepare the reports using the outline and template that BMS approved during the planning activities, as previously described in this section. The information that, at a minimum, HSAG will include in the MCOs' reports will address:

- HSAG's summery of its findings, conclusions, and recommendations with respect to the MCOs' performance in complying with the BMS-specified requirements for providing quality, accessible, and timely care and services to its beneficiaries.
- For each of the standards reviewed (e.g., provider selection and retention, content of the enrollee handbook, enrollee/provider appeals, etc.), HSAG's assessment of the MCOs' performance strengths and any areas requiring corrective action to bring performance into full compliance with the requirements.
- As applicable to each contract year, BMS's process, requirements, and the timelines for the MCOs to develop and submit to BMS their corrective action plans for each requirement that HSAG scored as less than fully compliant (i.e., *Partially Met* or *Not Met*).

States for which HSAG is the EQRO differ in the amount and detail of information they want included in the body of the report and in appendices. HSAG recommends—and most of the states prefer—limiting the body of the report to HSAG's high-level summary findings, conclusions, and recommendations considering the MCO's performance strengths and areas requiring improvement, and including as appendices the detailed information that typically includes:

- The completed compliance review tool that serves as the permanent record of HSAG's findings for each requirement, the score assigned to the MCOs' performance, and any actions required to bring performance into compliance.
- A detailed description of the methodology HSAG followed in conducting the compliance review activities and the sources of data it used to reach the findings, scores, and recommendations to improve performance.
- A list of the MCO and HSAG participants and other individuals participating in or observing the on-site review activities.

If BMS requests that HSAG identify a different structure for organizing and presenting the information, HSAG will work collaboratively to develop a report template according to BMS specifications, and include in the MCO reports for each contract year the information that will be the most useful and value-added for both BMS and the MCOs.

The following outline is one example of a table of contents for an MCO compliance with standards report that HSAG has used for some of the other states under its EQRO contracts. For this example, HSAG had reviewed the CMS Structure and Operation Standards and the associated state Medicaid agency contract requirements.

1. ***Overview***

   Background

   Description of the 2011-2012 External Quality Review of Compliance With Standards

2. ***Performance Strengths and Areas Requiring Corrective Action***

Summary of Scores for Each Standard and Overall

Standard I—Provider Selection
Strengths
Areas Requiring Corrective Action (Note: Areas where HSAG scored the MCO's performance as either *Partially Met* or *Not Met* and what the MCO needed to do to improve its performance).

Standard II—Credentialing and Recredentialing
Strengths
Areas Requiring Corrective Action

Standard III—Enrollee Information
Strengths
Areas Requiring Corrective Action

Standard IV—Enrollee Rights
Strengths
Areas Requiring Corrective Action

Standard V—Confidentiality
Strengths
Areas Requiring Corrective Action

Standard VI—Grievance System—Enrollee Grievances, Appeals, and State Fair Hearings
Strengths
Areas Requiring Corrective Action

Standard VII—Subcontractual Relationships and Delegation
Strengths
Areas Requiring Corrective Action

3. ***Corrective Action Plan Process***

Appendix A. Review of the Standards (HSAG's completed compliance review tools documenting its findings, scores, and any areas requiring MCO corrective actions.)

Appendix B. On-Site Review Participants

Appendix C. Review Methodology (A table that briefly described each step associated with HSAG's methodology for conducting the review, its scoring methodology, and its steps in reporting the findings, conclusions, and recommendations.)

Appendix D. Corrective Action Plan (A template HSAG provides to the MCOs to document their proposed corrective action[s] to submit to the state Medicaid agency in response to any findings with a *Partially Met* or a *Not Met* score.)

HSAG will provide electronic and color-printed/bound hard copies of the final MCO compliance review summary reports to BMS and each MCO.

PROVIDING TECHNICAL ASSISTANCE TO THE MCOS

As a key component of its compliance review activities HSAG will identify areas where the MCOs' failures to perform at required levels appeared to be a function, in part, of one or more of the following deficiencies or other barriers and where technical assistance would be helpful to them:

Deficiencies in:

- Fully understanding the requirements and/or the level and detail of the performance and/or outcomes required.
- Identifying, implementing, and requiring that its subcontractors implement targeted corrective actions that are selected based on a thorough root-cause analysis of the deficiency in performance.
- Conducting frequent and substantive training and education for all affected parties when implementing new or modifying current policies/procedures/processes.
- Conducting performance monitoring that is sufficient in frequency and content to detect substandard performance. This is particularly critical when implementing new requirements or making changes to existing policies/procedures and requirements for the MCO and/or its network service providers and any individuals or organizations to which the MCO has delegated certain MCO administrative functions.
- Continuing to monitor performance results periodically to determine if improved performance is sustained over time.

HSAG reviewers are invaluable in their knowledge and ability to provide technical assistance and guidance when collaboratively working with the state Medicaid agencies and their contracted MCOs. HSAG has extensive and recognized experience and expertise in designing and providing targeted technical assistance across a broad scope of performance areas and in obtaining improved outcomes across multiple indicators, including beneficiary health outcomes.

In the first year following contract award, HSAG will provide up to 20 hours of focused, structured, and scheduled technical assistance or training to the MCOs, and at BMS's request, to others.

HSAG will work collaboratively with BMS to identify the focus for the technical assistance activities and anticipates that most of the technical assistance presentations/consultations will be effectively and efficiently provided via HSAG's teleconferencing/Webinar capabilities that support attendees' full and active participation and access to all associated HSAG presentation materials. In addition, HSAG will be available to BMS and the MCOs to respond to questions and provide technical assistance that can be accomplished through e-mails and telephone calls.

Finally, throughout the stages of planning, preparing for and conducting the reviews, and preparing final reports of results, HSAG will discuss with BMS (and as applicable and requested by BMS and the applicable MCO or MCOs) any substantive findings related to:

- Issues or problems identified regarding the accessibility, quality, and utilization of services provided to beneficiaries.
- Assessment of the MCOs' compliance with program, systems, and clinical requirements, as outlined in the BMS/MCO contract and as evaluated during HSAG's desk and on-site review activities.
- Examples of CMO "best practices" and, based on the wealth of information HSAG has about other managed care organizations, share other best or emerging practices related to successful processes and performance that HSAG has encountered across its EQRO contracts.

In addition, HSAG's significant EQRO experience makes it possible to propose creative, competitive solutions to meet the needs and goals of BMS and its MCOs for the Mountain Health Trust (MHT) program, services, beneficiaries, and providers. HSAG's recommendations will incorporate those strategies, processes, and measures that have proven to be effective in improving performance or cost-effectiveness, and generating value-added enhancements to the accessibility, quality, and timelines of services for HSAG's EQRO clients and their MCOs, providers, and beneficiaries. While HSAG may observe what would appear to be examples of best practices, HSAG places high importance on ensuring that the information and performance results observed and reported through its compliance reviews generates real and sustained improvement and are measured using valid and reliably collected data when recommending or using them as examples and models of performance improvement strategies.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Executive Director. Project Oversight	Bonnie Marsh, BSN, MA
WVPD/CR	Director, EQRO Project Director and Compliance Reviewer	Debbie Chotkevys, DHA, MBA
PD/CR	Director, Project Director for Compliance Activity and Compliance Reviewer	Diane Christensen, MC, LPC
CR	Project Director, Compliance Reviewer	Barbara J. McConnell, MBA, OTR
DRD	Director, Reports Department	Cheryn Wall, EdD
EDIT	Editor	Joy Valentine, MA
STW	Senior Technical Writer	Kris Ellis, BS

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Initiate the compliance review Activities			
Conduct initial discussions and reach agreements with BMS related to: ➢ The work plans/timelines for HSAG's MCO compliance review activities; e.g., preparing tools, conducting the desk review of MCO documents and on-site reviews/interviews; and preparing and delivering to BMS and the MCOs the individual MCO compliance review draft and final reports. ➢ Identifying areas HSAG will review; i.e., confirm with BMS the scope of the review and the standards/MCO contract requirements HSAG will review. ➢ Obtaining background information and all key documents from BMS..	WVPD/CR, PD/CR, BMS	4/2/12	4/16/12
In collaboration with BMS, prepare for and conduct an on-site orientation for the BMS and MCOs for HSAG's compliance review activities.	WVPD/CR, PD/CR, BMS	4/16/12	5/11/12
Develop the draft review tool(s) and the MCO compliance report template			
Prepare for BMS's review and approval HSAG's proposed compliance review tool(s) and the template for the draft individual MCO compliance reports.	PD/CR, DRD, EDIT, STW	4/18/12	5/11//12
Submit the drafts for BMS review and receive BMS feedback.	PD/CR, BMS	5/14/12	5/25/12
As needed, revise and finalize the documents.	PD/CR, DRD, EDIT, STW	5/29/12	6/6/12
Conduct the pre-on site review activities			
Establish and agree on the schedule for HSAG's desk- and on-site review activities for each MCO.	PD/CR, BMS, MCOs	6/6/12	6//13/12
➢ Prepare for BMS review and approval a packet of information for the MCOs describing HSAG's compliance review activities (i.e., office-based desk review of documents and on-site review of additional documents and interviews). ➢ As needed, based on BMS comments, revise and finalize the materials.	PD/CR, DRD, EDIT, STW, BMS	6/6/12	6/19/12
Provide the materials to the MCOs with the customized schedule and agenda for each MCO's on-site review.	PD/CR	6/20/12	6/20/12
Schedule and conduct a pre-on-site conference call with BMS and the MCOs to answer any questions they have about the materials, HSAG's desk- and on-site review activities and schedule, and the documentation required from them for each activity.	PD/CR, WVPD/CR, CR, BMS, MCOs	6/25/12	6/29/12
Receive from the MCOs and review each MCO's documentation; draft HSAG's preliminary findings in the compliance review tool; identify additional documents to request each CMO have available on site; and, develop HSAG's questions for the on-site interviews.	PD/CR, WVPD/CR, CR	7/19/12	8/30/12
Conduct the on-site review activities			
Conduct the individual MCO on-site reviews, including a review of documents requested to be available and conducting	PD/CR, WVPD/CR,	9/4/12	9/18/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
interviews (Assumes three days on-site for each MCO and weekend or day between each).	CR		
Prepare all draft sections of the individual MCO compliance reports to submit to BMS and the applicable MCO for review and comment			
Analyze and compile the findings from HSAG's desk- and on-site reviews and document findings and scores for each requirement HSAG reviewed and scores for each standard (groups of associated requirements) in the compliance review tool.	PD/CR, WVPD/CR, CR	9/7/12	11/16/12
Draft all narrative sections of the draft report.	PD/CR, WVPD/CR, CR DRD, EDIT, STW	9/17/12	11/16/12
Submit to BMS and the MCOs the draft reports for review and comment.	PD/CR	11/16/12	11/16/12
Receive BMS and MCO comments on the draft reports and discuss the comments with BMS and any changes HSAG or BMS recommends based on the comments.	PD/CR, BMS	11/21/12	12/4/12
As applicable, revise the reports.	PD/CR, WVPD/CR, CR DRD, EDIT, STW	12/7/12	12/17/12
Prepare and submit the final reports to BMS and the MCOs			
Prepare the final reports.	PD/CR, DRD, EDIT, STW	12/17/12	12/17/12
Based on BMS' request, submit electronic and/or hard copies of the final reports to BMS and the applicable report to each MCO.	PD/CR	12/17/12	12/17/12
Conduct additional time-limited planning and technical assistance calls/Webinars with BMS and/or its MCOs.	PD/CR, WVPD/CR, CR	Ongoing	

2.4.5 HSAG's Plan to Monitor Medicare and Private Standards and Processes for Review and Make Recommendations to BMS

2.4.5 The Vendor should propose a plan to monitor the Medicare and private standards and processes for review and make recommendations to BMS as to where it may be appropriate to use the Medicare or private review to avoid duplication.

EXPERIENCE WITH SIMILAR PROJECTS

HSAG has:

- Conducted extensive research and requested and received significant technical assistance, guidance, and consultation from multiple content-area experts and oversight/regulating bodies, including CMS.
- Reviewed countless Medicare and private organizations' regulations and monitoring processes and tools to ensure that it is fully informed about deeming and when it can and cannot be applied to Medicaid managed care organizations.
- Obtained considerable experience and competency in working with its EQRO-contracted state Medicaid agencies to understand both the requirements and complexities of deeming and to conduct studies/evaluations that determine if a state agency may be able to apply deemed status for some of the federal Medicaid managed care regulations and the associated MCO contract standards.

HSAG also considers itself—and is considered by CMS and the state Medicaid agencies with which it works—an expert in the Medicaid managed care 42 CFR §438 regulations.

The two most recent examples of HSAG's work with its state Medicaid agency contractors related to deeming were those for the State of Hawaii, Med-QUEST Division, and for the State of Ohio, Department of Job and Families Services.

STATE OF HAWAII, MED-QUEST DIVISION

Beginning in 2009, in collaboration with and at the request of Med-QUEST, HSAG initiated a comprehensive project focused on determining opportunities for "deeming compliance" and non-duplication of QUEST managed care health plan reviews. The activities HSAG conducted included:

- Developing guiding principles (e.g., the State agency has the authority and responsibility to make all decisions as to whether, and to what extent, a contracted managed care plan may be deemed compliant for purposes of exercising this option).
- Proposing a decision model with specific steps, starting with ensuring the State's quality strategy to identify the standards for non-duplication.
- Implementing each of the steps for conducting the activity.
- Preparing and submitting to the State a report describing methodology, activities, findings, and conclusions/recommendations.

In addition, HSAG assisted the Med-QUEST Division in crafting language for its quality strategy and its MCO contract, and provided technical assistance and training related to the non-duplication strategy. Med-QUEST implemented the non-duplication strategy for the Hawaii MCOs during the past year for the credentialing standards.

HSAG's report for this activity is available in the public domain at the Web address http://www.med-quest.us/PDFs/Quality%20Strategy/Nonduplication%20Strategy%20and%20Crosswalk.pdf

STATE OF OHIO, DEPARTMENT OF JOB AND FAMILY SERVICES (ODJFS)

As part of its EQRO contract requirements, and with a goal of reducing duplicative administrative activities and costs, ODJFS contracted with HSAG to determine the feasibility of implementing a non-duplication strategy for the access, structure and operations, and measurement and improvement standards that CMS, at 42 CFR §438.360, designates as eligible for "deeming." Since all of the ODJFS MCOs were accredited by either URAC or NCQA, HSAG used these standards to determine the extent to which they were equivalent to the federal regulations.

HSAG reviewed extensive literature, including other states' experiences and processes in similar projects and completed crosswalks to identify those standards eligible for deeming (e.g., NCQA and URAC standards) compared to specific CFR access, structure and operation, and measurement and improvement standards. HSAG used strict criteria to determine whether the standards are eligible for deeming (i.e., the accreditation standard/element had to be 100 percent comparable with the CFR and the review conducted within the time period under review). HSAG prepared tables with a summary of findings, which contained each CFR eligible for deeming per CMS; the NCQA and URAC percentage comparability with each; ODJFS contract requirement related to each CFR; and HSAG's recommendations for the ODJFS standard to be eligible for deeming based on NCQA's and URAC's percentage comparability.

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is the Executive Director, State & Corporate Services for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debbie Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work and contract deliverables, and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's quality strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the

Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which she has reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Prior to joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Diane Christensen, LPC, is a Director, EQRO Services, with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for designated Services Division projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of

work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona-Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid-enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care System (ALTCS) contractors. She performed analysis and interpretation of federal and State regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Master of Counseling Degree from Arizona State University and a Bachelor of Science in Secondary Education (English/Speech) Degree from West Virginia University.

Barbara McConnell, MBA, OTR, is the Project Director for the State & Corporate Services Division at HSAG. She is responsible for analyzing and evaluating pertinent information for physical and behavioral health organization on-site reviews, and for coordinating various contract activities and deliverables. Ms. McConnell is responsible for reviewing desk audit materials, on-site audit activities, and preparation of the report of audit findings for HSAG's Colorado physical and behavioral health EQRO contract. She also participates as part of the compliance team for on-site medical record reviews, including reviewing organizational standards and compliance, assisting the project team with accurate and supportive recommendations, and providing client feedback and reports on review findings in follow-up to site visits.

Ms. McConnell is a registered occupational therapist with over 20 years of experience in variety of health care settings, including mental health centers, hospitals, and rehabilitation centers. She also brings a thorough knowledge of the start-up and ongoing management of rehabilitative facilities, from developing collaboratives in the community and working with funding sources such as Medicare and Medicaid, to coordinating care plan programs to ongoing case management and quality improvement/assurance.

Ms. McConnell holds a Bachelor of Science Degree in Occupational Therapy from Ohio State University and a Master of Business Administration Degree from the University of Kansas.

Proposed Approach and Methodology

INTRODUCTION

Under certain national accreditation programs, the standards and requirements for managed care organizations are *similar* to the federal requirements for Medicaid MCOs.

To avoid duplication, the CMS "non-duplication" regulations (42 CFR §438.360) provide a mechanism for states to use information obtained from a Medicare or private organization's accreditation review to determine compliance with the federal requirement for an operational review. The review is to be conducted to determine the Medicaid managed care organizations' performance in complying with federal Medicaid managed care regulations for providing quality, timely, and accessible care and services to beneficiaries.

The regulations are presented in three groups of standards:

1. Access standards (42 CFR §438.206, §438.207, §438.208, and §438.210)
2. Structure and operations standards (42 CFR §438.214, §438.218, §438.224, §438.228. and §438.230)
3. Measurement and improvement standards (42 CFR §438.236, §438.240, and §438.242)

To qualify as an equivalent review, the Medicare and private accrediting body standards and reviews must be as stringent as the state Medicaid agency's standards for its contracted MCOs.

On the face of it, deeming seems like a simple and straightforward thing to do. Quite the opposite, it is, in fact, highly complex and demanding of absolute rigor, detail, and documented evidence that can be used in lieu of an EQRO evaluation and applied to certain CMS Medicaid managed care standards/requirements for a state's MCOs.

As with the similar projects HSAG has conducted to determine the feasibility of deeming as compliant with certain MCO requirements, HSAG will follow a methodical and detailed process for this activity.

The steps will include the following:

CONDUCT INITIAL DISCUSSIONS AND REACH AGREEMENTS WITH BMS

HSAG will schedule initial discussions with BMS to clearly define the scope of the activity for each year of the contract and reach agreements with BMS related to:

- HSAG's proposed work plan for conducting each step in the activity and providing the required deliverables for the first year of the EQRO contract.
- Sources, process, and timelines for HSAG to obtain essential background information and all key documents from BMS or other sources, as applicable.
- BMS's expectations and BMS/HSAG agreements as to the format and content of HSAG's deliverable(s) for this activity.

OBTAIN FROM BMS KEY INFORMATION AND DOCUMENTATION

HSAG will obtain from BMS and review:

- Information as to the national accreditations applicable to each of the MCOs.
- The Medicare regulations/standards and private organization (e.g., NCQA and URAC) standards used for the MCO certification and accreditation(s).
- The evaluation tools used by each Medicare and accrediting body and the most recent survey results for each MCO.
- The current BMS contract with the MCOs.

CONDUCT EACH STEP OF THE ACTIVITY

- If not all MCOs are certified by Medicare or accredited by the same private organization, HSAG will reach an agreement with BMS as to which sets of standards (Medicare and/or a private accrediting body) are the most appropriate to use for each MCO. It is always preferable and allows for comparing findings and results across the three MCOs if the standards HSAG uses are the same for all MCOS (e.g., Medicare and/or NCQA)
- HSAG will propose and discuss with BMS HSAG's recommendations for its proposed model, approach, sequential steps, and the guiding principles and criteria it will use in determining the potential for implementing a non-duplication strategy. For deemed status, the MCOs must be in compliance with Medicare or a national accreditation organization's standards and the standards must be comparable to the state Medicaid agency's standards to comply with the 438(g) and the EQR activities described in 438(b)(3).
- HSAG will conduct a detailed review of the selected standards (Medicare and/or private organization) and evaluate their comparability to those in the MCO contract.
- HSAG will prepare a draft cross-walk of those MCO contract standards that appear to be comparable and meet all the CMS requirements for deemed status. The crosswalk will include, at a minimum for each standard, the Medicaid managed care regulation, BMS's associated MCO contract requirement(s), the associated Medicare or accrediting body standard, and HSAG's determination as to whether the standard qualifies for deeming.
- HSAG will discuss its findings, conclusions, and recommendations with BMS and respond to any BMS questions/requests for further clarification.

PREPARE DRAFT AND FINAL REPORT OF HSAG'S FINDINGS AND RECOMMENDATIONS

- HSAG will prepare and provide to BMS a draft report that describes HSAG's approach to the activities, methodology, findings, and recommendations.
- HSAG will receive and discuss BMS's comments and, if applicable, revise the report.
- HSAG will prepare and deliver the final report to BMS.

DISCUSS AND REACH AGREEMENTS WITH BMS RELATED TO TIMING FOR IMPLEMENTATION

- Based on HSAG's non-duplication strategy project findings and recommendations it will discuss with BMS the feasibility and timing for HSAG's use of "deemed compliance" for

requirements in the EQR of compliance. To meet deemed status, BMS must have identified in its quality strategy provided to CMS those standards for which it will use information from a Medicare or private accreditation organization review, and it must demonstrate that they were duplicative of BMS's or its EQRO's review.

- HSAG will make recommendations and discuss with BMS a potential strategy for phasing in its deeming of compliance, and the timing and scope of the implementation.

In addition to this evaluation and recommendations to BMS about the nonduplication strategy, HSAG will also examine, on a regular basis, the methodologies and processes used in the health care accreditation industry and by national and state certification bodies (Medicare and state licensing agencies). HSAG itself is URAC- and NCQA-accredited and, therefore, quite familiar with the standards and processes used in evaluating and accrediting health care organizations. In addition, HSAG subscribes to the online resources available through NCQA's Web site, which include all current accreditation and certification program standards, the guidelines and intent for each program standard, and all policies and procedures NCQA uses in its evaluation and scoring process. Consistent with NCQA's processes, HSAG follows, for example, procedures for a "look back" period and for sampling and scoring during the review of actual credentialing and recredentialing files of MCOs. HSAG has designed other record review tools and medical record abstraction processes that it used during EQR activities to also align with industry standards and practices, and will continue to keep current in these processes and make recommendations for changes or new efficiencies to the BMS as indicated.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD/CR	Director, EQRO Project Director and Compliance Reviewer	Debbie Chotkevys, DHA, BBA
PD/CR	Director, Project Director for Compliance Activity and Compliance Reviewer	Diane Christensen, MC, LPC
CR	Project Director, Compliance Reviewer	Barbara J. McConnell, MBA, OTR
DRD	Director, RFPs & Reports Department	Cheryn Wall, EDD
EDIT	Editor	Joy Valentine, MA
STW	Senior Technical Writer	Kris Ellis, BS

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Discuss and reach agreements on the scope of HSAG's activity, timelines, and required deliverable(s)			
Conduct initial discussions and reach agreements with BMS related to: ➢ The scope of the activity for the first EQRO contract year. ➢ The work plans/timelines for HSAG to conduct a review of (1) the Medicare standards and processes used for the review of the MCOs, (2) private standards and processes	WVPD/CR, PD/CR, BMS	4/2/12	4/12/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
used for the review of the MCOs and processes for review, and (3) make recommendations to BMS as to where it may be appropriate to use them to avoid duplication in HSAG's compliance reviews. ➢ Sources for obtaining background information and obtaining all key documents from BMS. ➢ Expectations and preferences for HSAG's deliverable (format and content). ➢ Whether HSAG is to use applicable "deemed" status to replace its document review and interviews associated with any of the applicable requirements for its compliance reviews for the first year of its EQRO contract or only for subsequent years.			
Obtain and review key documents			
Obtain from BMS the Medicare and/or private organization standards. or If not all the standards/requirements for the oversight and monitoring entity were applicable—i.e., BMS does not include them in its MCO contract requirements—obtain from BMS and review the specific Medicare regulations and/or private organization standards (e.g., NCQA) applicable to the MCOs.	WVPD/CR, PD/CR, CR	4/16/12	4/20/12
Obtain from BMS and review the monitoring tools used for the most recent MCO Medicare and/or private organization evaluations, and the reports of findings/results provided to the MCOs.	BMS, WVPD/CR, PD/CR, CR	4/16/12	4/20/12
Obtain from BMS and review the current BMS/MCO contract requirements and any BMS-planned changes to them.	BMS, WVPD/CR, PD/CR, CR	4/16/12	4/20/12
Prepare a draft crosswalk of the BMS/MCO contract standards/requirements compared to the standards reviewed by Medicare and/or a private organization (e.g., NCQA)			
Identify those standards/requirements evaluated by Medicare and/or private organizations that appear to be identical to, or very similar to, (1) the BMS contract requirements and (2) the associated 42 CFR 438 standards that could potentially be considered as having deemed status for the purpose of EQRO reviews.	WVPD/CR, PD/CR, CR	4/23/12	5/4/12
For the above standards/requirements, review the evidence of performance required, and the monitoring methodology and tools used for the Medicare and/or private organization to determine if they were sufficient as "equivalent" to the methods HSAG would use and information it would obtain consistent with the CMS EQRO Protocol.	WVPD/CR, PD/CR, CR	4/23/12	5/4/12
Prepare a crosswalk documenting a comparison of the BMS contract requirements with the Medicare and/or private organization's standards and processes for evaluating compliance.	WVPD/CR, PD/CR, CR	5/9/12	5/18/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Prepare and provide to BMS a draft and final report			
Prepare and provide to BMS HSAG's draft summary report of HSAG's process in conducting the review and its findings and recommendations as to which MCO contract requirements that were reviewed by Medicare or a private organization could be considered as having deemed status for the purpose of EQRO reviews.	OPD, WVPD/CR, PD/CR, CR, DRD, EDIT, STW	5/9/12	5/30/12
Receive and discuss BMS comments.	BMS, WVPD/CR, PD/CR, CR	5/31/12	6/8/12
As applicable, revise and provide the final report to BMS.	OPD, WVPD/CR, PD/CR, CR, DRD, EDIT, STW	6/11/12	6/15/12

2.4.6 HSAG's Plan to Review Unique MCO Activities

2.4.6	The Vendor should propose a plan to review MCO activities that are unique to the MHT program, such as review of grievance and appeals processes, timelines, and notifications regarding State fair hearing processes and Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach and notices; notify MCOs of the preliminary review findings and request corrective action plans for each area in which the MCO has not demonstrated sufficient compliance; and provide clarification and/or technical assistance to MCOs as necessary to develop and implement corrective action plans.

Experience With Similar Projects

HSAG has extensive experience in working collaboratively with its Medicaid state agency clients in conducting reviews of:

- CMS' Medicaid managed care and Children's Health Insurance Program (CHIP) regulations and the state agencies' requirements for their contracted managed care organizations (MCOs).
- The MCOs' performance in complying with the requirements.

As part of its review of key state Medicaid agency documents and contracted MCOs' documents, HSAG identifies those requirements that are unique to each state's program.

It is HSAG's experience that some MCOs find that understanding the intent and details of the federal Medicaid managed care requirements challenging, and have difficulty translating the requirements into documented evidence and performance results that demonstrate compliance. Examples of variables that can contribute to this include:

- Different naming conventions used in the federal requirements and those used in state rules/regulations, policies/procedures, and MCO contracts.
- For national organizations with Medicaid MCOs in more than one state, corporate policies, procedures, and practices that do not conform to state-specific requirements.
- State Medicaid managed care and CHIP programs that have several layers of administration and more than one service delivery model where either the requirements have not been adequately communicated, or are not equally applicable, to each layer and/or model.
- Insufficient training in understanding the requirements and what is required at all levels of the programs (state Medicaid agency, MCOs, providers and delegates, etc.) in order to comply with them.

In HSAG's experience, examples of some of the more challenging federal requirements are those related to beneficiary appeals, grievances, and requests for state fair hearings; delegation of MCO administrative functions; and, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

With each of its state EQRO clients, and before developing the tools for the EQRO activities, HSAG carefully reviews the Medicaid state agency's rules, regulations, and contract requirements applicable to its MCOs. HSAG is detailed in its reviews to identify those state-specific and unique requirements applicable to the MCOs. HSAG reviews each requirement to ensure that it is not in conflict or inconsistent with the associated requirement in the federal 42 CFR §438 regulations applicable to the state's MCOs.

In developing the tools for conducting the compliance review activities, HSAG is diligent in ensuring that the requirements/criteria in the tools against which HSAG evaluates the MCOs' performance include the unique/state-specific requirements.

Through its vast experience in conducting the review of compliance activities for multiple states and their managed care organizations and in designing and conducting focused studies, HSAG has been able to provide to the state agencies and their MCOs recommendations, targeted technical assistance, and training in meeting both the federal Medicaid managed care regulations and the state's unique requirements. HSAG's experience has also provided it with a wealth of examples of other state agencies' MCO contracts and their MCOs' provider contract provisions, and examples of MCOs best practices in meeting the requirements.

As requested by the state, HSAG has also reviewed numerous MCOs' proposed corrective actions plans (CAPs) and provided feedback to the state agency and the MCOs as to the sufficiency of the proposed corrective/improvement strategies and the appropriateness of timelines proposed for implementation based on the severity of the deficiency and urgency for correction. For individual MCOs or PIHPs, and if applicable to several or all of a state's MCOs/PIHPs, HSAG works collaboratively with the state to prepare and deliver targeted technical assistance and training to support the organizations in improving their performance and complying with unique state requirements such as those for state-defined geographic access to services (i.e., miles/drive time to each provider type), beneficiary grievances and appeals, and timely access to services that meet the periodicity schedules for providing well-child visits.

To illustrate, the following are just a few examples of HSAG's technical assistance activities and focused review activities conducted to support the states and their contractors in meeting their unique requirements.

- For several states (including Colorado, Georgia, Hawaii and Utah) and their contractors, HSAG prepared and provided training on the federal and state-specific requirements related to the beneficiary and provider grievance, appeal, and state-fair hearing processes. The trainings addressed topics such as:
    - Clarifications related to the terminology and definitions used by CMS, the state, and the MCOs.
    - Required timelines associated with each of the processes.
    - The minimum content for required beneficiary communications for things such as notices of actions, grievance and appeal acknowledgment and resolution letters, and member handbook and provider manual information about the grievance appeal and state fair hearing processes.

- For the State of Colorado, the State contracted with HSAG to conduct a study to determine its behavioral health prepaid inpatient health plans (PIHPs) performance in meeting the State's timely access to appointment contract requirements. HSAG worked collaboratively with the State to develop a script and protocol for HSAG to use in conducting calls to the PIHPs' customer service or access lines, and also to a small sample of high-volume behavioral health services providers, to determine their next available appointment time for specified appointment types, and the ease of and response time required to obtain the information. HSAG provided a report to the State with its findings and recommendations to improve the PIHPs' performance.
- For the State of Utah, HSAG prepared and provided a WebEx conference training and technical assistance that included a PowerPoint presentation for the organizations to have as a permanent guide to use as a reference. The presentation included topics such as the difference between grievances and appeals and the requirements associated with each; the required member/provider notices of action and/or other required notices and communications and the minimum required content of each; and the CMS and state-specific timelines associated with each requirement. HSAG has been working with the Ohio Department of Healthcare and Family Services (ODJFS) and contracted managed care plans (MCPs) related to their Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach and notices. ODJFS convened a statewide EPSDT Healthcheck Collaborative performance improvement project to increase awareness about preventive health care services for children. This statewide quality improvement initiative strives to improve preventive and developmental screenings and follow-up care by educating providers. HSAG has guided the MCPs in the development of statewide interventions. One of those interventions included outreach to provider offices with low penetration rates for EPSDT services and evaluated how the provider office used the missed services report that each plan produces for the members who have not received EPSDT services. As part of the outreach to the provider's office, the MCP staff also interviewed office staff to identify assistance that the office needed from the MCPs to perform outreach to members for EPSDT services. In addition, the collaborative developed a member Healthcheck brochure that was distributed to provider offices, FQHCs, state health departments, schools, and many other community centers.

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is the Executive Director, State & Corporate Services for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debbie Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work, contract deliverables, and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which time she has reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Before joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Diane Christensen, MC, LPC, is a Director, EQRO Services, with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for designated division projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid-enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Master of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Barbara McConnell, MBA, OTR, is a Project Director for the State & Corporate Services Division at HSAG. She is responsible for analyzing and evaluating pertinent information for physical and behavioral health organization on-site reviews, and for coordinating various contract activities and deliverables. Ms. McConnell is responsible for reviewing desk audit materials and on-site audit activities, and for preparing the report of audit findings for HSAG's Colorado physical and behavioral health EQRO contract. She also participates as part of the compliance team for on-site medical record reviews, including review of organizational standards and compliance, assisting the project team with accurate and supportive recommendations, and providing client feedback and reports on review findings in follow-up to site visits.

Ms. McConnell is a registered occupational therapist with over 20 years of experience in a variety of health care settings, including mental health centers, hospitals, and rehabilitation centers. She also brings a thorough knowledge of the start-up and ongoing management of rehabilitative facilities, from development of collaboratives in the community and working with

funding sources such as Medicare and Medicaid, to coordinating care plan programs for ongoing case management and quality improvement/assurance.

Ms. McConnell holds a Bachelor of Science Degree in Occupational Therapy from Ohio State University and a Master of Business Administration Degree from the University of Kansas.

Proposed Approach and Methodology

HSAG's proposed approach and methodology for conducting this activity is consistent with its proposed approach and methodology for conducting the annual reviews of the MCOs' compliance with standards that BMS established to comply with the requirements of 42 CFR 438.204(g), as well as other components of the Mountain Health Trust (MHT) MCO contract. While HSAG has separately prepared this narrative describing its proposed approach and work plan/timelines for the very specific tasks within this activity, for efficiency, HSAG is proposing to conduct and report its findings for this activity as part of its review of the MCOs' annual compliance review.

IDENTIFY MCO ACTIVITIES THAT ARE UNIQUE TO THE MHT

Request from BMS and Review Key Documents

In preparing for HSAG's review activities, HSAG will request from BMS and review certain key documents needed for the reviews (State Quality Strategy, BMS/MCO contract, applicable State statutes/rules), and any other documents BMS identifies as important for HSAG to review that describe MCO requirements/activities unique to the MHT program.

Discuss and Reach Agreements with BMS about Unique MCO Activities to be Reviewed

Following its review of the key documents, HSAG will schedule one or more conference calls with BMS to discuss (1) BMS' priorities for focused review areas to be included in the annual compliance review, and (2) the scope of the focused review topic and any preferences for review methods.

Prepare HSAG's Tool for Monitoring the MCO Requirements for the Unique Focused Area(s) of Review

In describing its activities for conducting the compliance review activities, HSAG has proposed to use the MCO contract requirements as the basis for developing HSAG's MCO compliance review tool. Following BMS and HSAG's agreements about the additional requirements/activities unique to the MCOs, HSAG will ensure that the compliance review tool submitted to BMS for review and approval includes the focused review requirements.

REVIEW MCO ACTIVITIES THAT ARE UNIQUE TO THE MHT

HSAG proposes to conduct its review of the MCOs' unique activities as part of HSAG's MCO compliance review activities (i.e., requesting and reviewing MCO documentation and interviewing key MCO staff members). As with each of the requirements it reviews, HSAG will be detailed in its review of the requirements/activities that are unique to the MHT program to

ensure that accurate conclusions are reached about compliance with these focused areas and MCO processes.

NOTIFY MCOS OF THE PRELIMINARY REVIEW FINDING

During the on-site interviews and as part of the on-site exit session, HSAG reviewers will:

- Provide feedback to the MCOs related to HSAG's preliminary findings for those unique requirements where HSAG's findings were that they did not appear to be in full compliance.
- Describe the MCO actions that would be required to bring their performance into compliance.
- Provide examples of other MCOs' approaches and strategies that have proven effective in complying with similar requirements.

PROVIDE DRAFT AND FINAL REPORTS OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

HSAG will include in its draft and final compliance review report for each MCO the findings for each of the unique requirements HSAG evaluated, the score assigned to the MCO's performance in complying with the requirement (*Met*, *Partially Met*, *Not Met*, or *NA*), and, any actions the MCO must take to bring its performance into compliance.

REQUEST AND REVIEW CORRECTIVE ACTION PLANS

In its final compliance report for each MCO, HSAG will include a document for the MCO to use in preparing and submitting to BMS and HSAG its corrective actions plans (CAPs). The MCO-specific template will include each requirement for which the MCO received a performance score of *Partially Met* or *Not Met*, HSAG's findings, and the MCO actions required to comply with the requirement. For each requirement, HSAG will provide a template for the MCO to use to document its proposed corrective action(s), the MCO staff member(s) or other individuals responsible for implementation, and the proposed timeline.

MCO's Interventions Planned	Individual(s) Responsible	Proposed Completion Date

HSAG and BMS will reach agreements as to the length of time the MCOs have to prepare and submit to BMS and HSAG their proposed CAPs. HSAG proposes 30 calendar days as a reasonable and sufficient period.

HSAG will review and provide its feedback to BMS for each proposed MCO CAP, commenting on its assessment of the sufficiency of the MCOs' proposed interventions in bringing performance into compliance; the appropriateness of the level of staff within the MCO proposed as responsible for implementation; and based on the nature of or urgency for correction, the appropriateness of the proposed timelines.

For those MCO-proposed CAPs that HSAG and BMS agree are not sufficient, HSAG will make recommendations and discuss with BMS the time allowed for the MCO to revise and resubmit the CAP. HSAG, or if BMS prefers, BMS will provide this information to the MCOs. When

HSAG and BMS agree that the CAPs are sufficient, BMS will notify the MCOs that the CAPs are approved and they may begin implementing the improvement actions.

PROVIDE TECHNICAL ASSISTANCE TO MCOS ON CORRECTIVE ACTION PLANS

In addition to providing preliminary findings during the on-site compliance review for each MCO, HSAG will prepare and provide MCO-specific technical assistance. The technical assistance will focus on those unique MHT requirements for which the MCO did not appear to clearly understand the level of performance required to comply with the requirement. For any unique standards for which HSAG found all three MCOs' performance was not fully compliant or their proposed CAPs were not sufficient, HSAG may recommend a group technical assistance session and will prepare and provide this assistance.

HSAG anticipates that most of the technical assistance activities can be effectively conducted through an exchange of documentation, e-mails, and/or prescheduled WebEx/conferencing calls with the MCO(s) and BMS.

HSAG is prepared to provide up to 20 staff hours of technical assistance.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD/CR	Director, EQRO Project Director and Compliance Reviewer	Debbie Chotkevys, DHA, BBA
PD/CR	Director, Project Director for Compliance Activity and Compliance Reviewer	Diane Christensen, MC, LPC
CR	Project Director, Compliance Reviewer	Barbara J. McConnell, MBA, OTR
DRRFP/RT	Director, RFPs & Reports Team	Cheryn Wall, EDD
EDIT	Editor	Joy Valentine, MA
STW	Senior Technical Writer	Kris Ellis, BS

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Identify MCO activities that are unique to the MHT program			
Request from BMS and review key documents (State Quality Strategy, BMS/MCO contract, applicable State rules, and other documents that BMS identifies as important for HSAG to review that describe MCO requirements/activities unique to the MHT. program	WVPD/CR, PD/CR, CR, BMS	4/2/12	4/16/12
Discuss and reach agreements with BMS as to those MCO activities that are unique to the BMS program.	WVPD/CR, PD/CR, CR, BMS	4/2/12	4/16/12

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Ensure that in preparing HSAG's tool for monitoring the MCO compliance, the tool includes those elements that appear to be unique to the MHT program.	WVPD/CR, PD/CR	4/18/12	5/14/12
Conduct a review of the activities			
Conduct a review of the unique activities as part of HSAG's MCO compliance review activities (i.e., request for and desk review of MCO documentation; and on-site review of additional documentation and interviews).	WVPD/CR, PD/CR, CR	6/18/12	9/17/12
During the on-site interviews, provide preliminary feedback to the MCOs-related HSAG findings and actions required to bring performance into compliance for the unique MHT activities.	WVPD/CR, PD/CR, CR	9/4/12	9/18/12
Report findings to BMS and the MCOs and as part of HSAG's draft and final MCO compliance review reports. For each requirement for which the MCOs' performance was not fully compliant, the reports will identify the areas of deficiency, corrective actions required to bring MCO performance into compliance, and a template for the MCOs to use in preparing their corrective action plans to submit to BMS and HSAG. MCOs are typically given 30 calendar days to submit their plans to the state Medicaid agency, and as directed by the agency, to the EQRO.	WVPD/CR, PD/CR, CR	11/15/12	12/17/12
Receive from the BMS or the MCOs, review, and evaluate the sufficiency of MCOs' proposed corrective action plans (CAPs)			
Evaluate the sufficiency of the MCOs' proposed CAPs.	WVPD/CR, PD/CR, CR	1/14/13	1/29/13
Prepare and provide to the applicable MCO and to BMS, HSAG's evaluation of the sufficiency of the CAPs, and for those determined as not sufficient, additional actions required to bring MCO performance into compliance.	WVPD/CR, PD/CR, CR	1/30/13	2/11/13
Provide clarification and/or technical assistance to the MCOs as necessary in developing and implementing sufficient CAPs			
As needed, conduct teleconference calls with BMS and an individual MCO to provide technical assistance and guidance and to answer any BMS or MCO questions related to developing and implementing CAPs where HSAG determined that performance was particularly challenging and the CAPs need to be comprehensive and detailed.	WVPD/CR, PD/CR, CR, BMS, MCOs		
As needed, conduct Webinar teleconference calls with BMS and with all MCOs to provide technical assistance and guidance and to answer any BMS or MCO questions related to developing and implementing CAPs where HSAG determined that performance across more than one MCO was not fully compliant and appeared to be particularly challenging.	WVPD/CR, PD/CR, CR, MCOs, BMS	2/12/13	2/25/13

2.4.7 HSAG's Plan to Accurately and Reliably Summarize the Performance of each MCO

2.4.7 The Vendor should address within their proposal how information provided to the Bureau accurately and reliably summarizes the performance of each MCO in each quality management area and identifies areas for corrective action and performance improvement.

Experience With Similar Projects

HSAG has performed EQR-related work since 1983 and has acquired and can demonstrate extensive skills, knowledge, and competence as an EQRO. Involvement in 14 states as a provider of EQR services has enabled HSAG to gain experience providing health care and quality review activities in numerous managed care organizations and for an array of program types. These experiences have resulted in a wealth of knowledge and expertise that HSAG draws upon to evaluate MCOs and provide state Medicaid agencies, such as BMS, with accurate, reliable summaries of MCO performance and quality, and to identify areas for correction and improvement.

In addition, HSAG has experience with other health care review activities outside of the traditional EQR activities. Below are examples of other health care review activities HSAG has provided its clients, which translate to and lend important expertise to HSAG's ability to evaluate MCO quality. (HSAG's specific EQR activity experience is described in the relevant sections of this RFP response.)

COLORADO

Blood Lead Screening Intervention Strategy

HSAG, working closely with a team of collaborators, implemented a statewide blood lead screening intervention for the Colorado Medicaid agency. The primary focus of the intervention was recipient and physician education. It was determined that a refrigerator magnet for parents and a wall poster for the physician office or waiting room would provide continual reminders for Medicaid recipients to have blood lead screening tests performed on their children. Based on Annual EPSDT Participation Reports (CMS-416), the rates of Colorado's Medicaid eligibles who received a blood lead screening test increased from 6.8 percent of 1- to 2-year-olds and 3.6 percent of 0- to 5-year-olds to 12 percent of 1- to 2-year olds and 6.0 percent of 0- to 5-year-olds, respectively.

Prenatal Care Survey

In a separate activity, HSAG conducted a member survey in English and Spanish of Medicaid recipients who entered prenatal care late. Surveys asked women if they received the amount of prenatal care they wanted and if not, asked that they identify some of the barriers to care. Women who indicated they did not believe prenatal care was important were asked to identify why. The results of this survey were used to help develop targeted interventions aimed at

improving prenatal care among Medicaid recipients enrolled in Colorado Medicaid's primary care physician program and its fee-for-service program.

OHIO

Emergency Department Collaborative

As part of its EQRO contract with the State of Ohio, HSAG was asked by the Ohio Department of Job and Family Services (ODJFS, the state Medicaid agency) to develop, implement, and evaluate a multi-city statewide collaborative whose purpose was to *Implement Medicaid Programs to Reduce Emergency Department (ED) Visits* (acronym IMPROVE) by Medicaid patients over the course of 18 months. The goal of this collaborative effort was to demonstrate improvement in emergency department utilization rates that would lead to systemwide policy change at the State level through interventions benefitting patients, providers, and payers. In conjunction with the eight Ohio Medicaid managed care plans, HSAG and its team of nurses, analysts, and quality specialists, under the clinical direction of its chief medical officer, assembled five regional steering committees, each composed of volunteer leaders in health care, community organizations, insurance plans, local government, and state and federal agencies. HSAG provided clinical leadership for the steering committees on interventions discussions. These steering committees met, discussed, formulated and are now implementing interventions aimed at reducing the rate of avoidable emergency department visits for Ohio's Medicaid population. It is anticipated that the final outcome of this HSAG-derived effort will result in the savings of millions of dollars in State Medicaid monies while at the same time improve the care delivered to patients and establish a model that can be adapted to Medicaid agencies across the country.

Program Evaluation

The Ohio Medicaid agency contracted with HSAG to evaluate the current design and make recommendations for four key managed care program areas:

- NCQA performance measures
- Pay-for-performance system for managed care plans
- Access standards
- Data quality strategies

The purpose of the program evaluation was to assist the state with providing optimal access and quality of care to Ohio Medicaid recipients in managed care. To evaluate the four key managed care program areas, HSAG conducted extensive research of existing practices and compared them to other states' Medicaid managed care programs. As a result of the evaluation, HSAG provided recommendations to optimize Ohio's program effectiveness and efficiencies, strengthen its Managed Care Quality Strategy, and help set program policy.

NEVADA

Reduction in Health Care Disparities

In 2007, the Nevada Division of Health Care Financing and Policy (DHCFP) and the MCOs formed the Racial and Ethnicity Disparities Work Group to address disparities in health care utilization and outcomes. Since then, HSAG has participated in the work group and provided guidance to DHCFP and the MCOs to develop the state's Cultural Competency Plan. The purpose of the work group was to identify disparities and improve health care quality for racially and ethnically disparate populations, including those with limited English proficiency. Efforts were geared toward identifying racial health care disparities within the Medicaid and Children's Health Insurance Program (CHIP) populations, making MCOs and providers aware of the disparities and developing strategies to eliminate the identified disparities in health care.

Pay for Performance Development

DHCFP requested that HSAG provide feedback on the incentive payment methodology and to validate the performance measures through the HEDIS audits. The HEDIS audits focused on the ability of the health plans to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. As part of the HEDIS audits, HSAG also explored the issue of data completeness of claims and encounter data to improve the rates for performance measures. Using the concept of pay-for-performance, DHCFP linked data completeness to an incentive payment with a 20 percent direct pass-through to the health plan's providers. The idea was to improve the quality and quantity of encounter data from providers, which, in turn, should help to improve the rates for performance measures. These pay-for-performance incentives, disincentives, and encounter data improvement efforts were combined to provide real, sustained improvements across all the performance measures.

HAWAII

Under its EQRO contract with the Hawaii Department of Human Services, Med-QUEST Division (MQD), HSAG developed and currently maintains a Level of Care Determination Database (HILOC) for the management of nursing facility level of care requests and approvals for the MQD's Medicaid recipients in need of these services. HSAG has ensured the development of a secure, Web-based application for coordinating the online submission of level of care requests from community providers and the QUEST Expanded Access health plans, Hawaii's MCOs that provide services and care coordination to aged, blind, and disabled members. Working collaboratively with the State, HSAG implemented an online tool that is capable of evaluating, monitoring, and managing the approval process (i.e., initial review, secondary physician review, and interrater reliability testing of all staff members). Based on an intuitive user interface, the HILOC application allows providers and plans to electronically submit requests for nursing facility level of care. HSAG staff members are responsible for maintaining MQD's statewide level of care determination database based on information collected through the HILOC application, and frequently generating SQL queries used to report both process and outcome reports.

In addition, HSAG database administrators developed an automated data transfer mechanism to interface with the MQD's payment system, thereby ensuring appropriate capitation payments to

participating Quest Expanded Access plans. Finally, HSAG has implemented a complete application and process support system that includes secure online, e-mail, and telephone help desk support and user reference materials and documentation.

TENNESSEE

HSAG's contract for services provided to the State of Tennessee's Medicaid agency, TennCare, requires an annual provider network adequacy assessment and on-site review. The analyses include calculating the travel time and distance a member must travel to see a primary care or specialty care physician as well as a ratio analysis. Time/distance and ratio standards are assessed for over 23 provider types. In addition to the network adequacy analysis, HSAG performs an on-site review of MCO credentialing and recredentialing files and primary care and specialty care physician contracts to ensure that MCOs are contracting with and credentialing qualified health care providers.

MEASURES MANAGEMENT SYSTEM

HSAG operates a Measures Management Department to assist CMS in developing and implementing an efficient, transparent, predictable, and well-coordinated management system that will produce and maintain scientifically sound, valid, and reliable quality measures across all settings.

The project objectives include the following:

- Implement a well-coordinated, efficient, transparent, and standardized set of processes and decision criteria to manage all CMS quality measures across all settings of care.
- Implement an electronic database to track measures throughout their life cycles, to provide an archive of measures developed and/or in use by CMS, and to provide management reports for CMS.
- Serve as part of CMS' measure support infrastructure for its various quality initiatives, including coordination with various major measure developers.
- Assist CMS in keeping abreast of new developments in the quality measurement field and provide support for its strategic planning on quality measurement.

HSAG has implemented both the Measures Management System (MMS) and the first iteration of the electronic database within CMS. HSAG has also produced a quarterly newsletter, Measures Monitor, which focuses on new developments in the quality measurement field. HSAG is assisting CMS' internal team in the planning and implementation of various quality initiations. CMS has deployed MMS in most of its health care quality measure development and maintenance activities. HSAG is working on enhancing the MMS based on users' feedback as well as incorporating features pertaining to new CMS quality initiatives. HSAG is also working with CMS to develop requirements for the next iteration of the electronic database to manage CMS' quality measures and to develop a set of performance metrics to measure efficiency and effectiveness of the system and to provide management information on an ongoing basis.

MEDICARE QUALITY IMPROVEMENT ORGANIZATION (QIO) EXPERIENCE

HSAG is contracted with CMS as the Medicare QIO in three states: Arizona, California, and Florida. For the 9th Scope of Work, which ended in 2011, HSAG worked on projects that spanned across the entire spectrum of the health community by providing intensive support to those providers most in need of QIO assistance and addressing key priorities of health care quality, including the identification and reduction of health care disparities across the continuum of care and across racial/ethnic, geographic, socio-economic, and demographic lines. HSAG's efforts to improve the quality of care and protect Medicare beneficiaries support CMS' three national themes of Beneficiary Protection, Patient Safety, and Prevention.

A crucial QIO role for each scope of work involves properly identifying and tracking valid measures of progress in each of the CMS task areas. A successful QIO such as HSAG must be able to sort through the multiple data sources available, identify those measures that are the most valid representations of task success, and reliably create and consistently track the measures. At HSAG the project and analytic teams collaborate in the selection/creation of appropriate measures. The analytic team analyzes and makes available to the project team the selected measures on a consistent basis and the project team uses the measures as part of the continuous quality improvement process required to meet all goals.

HSAG has served as the QIO for Arizona since 1979 and has participated in all nine Scopes of Work. During the three-year period of the 8th Scope of Work contract, HSAG worked extensively through its quality improvement settings—nursing homes, home health, hospitals, physician practices, and beneficiaries—on many projects related to beneficiary protection, patient safety, and prevention. Some examples of areas that merit attention include HSAG's work with the CMS regional office on beneficiary-related projects, HSAG's efforts related to patient safety, and HSAG's extensive work in support of electronic health records.

CAHPS® HOSPITAL SURVEY (HCAHPS)

HSAG has played a major role in the implementation of the CAHPS® Hospital Survey (HCAHPS Survey) since 2003. This standardized survey instrument is being used to collect and report information on hospital patients' perspectives on the care they receive. The HCAHPS project is part of a larger voluntary reporting effort that is being coordinated by the Quality Initiative: A Public Resource on Hospital Performance, and includes key organizations and stakeholders with an interest in reporting on hospital quality. It is CMS' ultimate goal that the publicly reported HCAHPS data are sufficiently valid and reliable to permit accurate comparisons of patient perspectives across hospitals. This is being accomplished by a carefully coordinated effort at the national level, encompassing multiple independent survey vendors and hospitals, using a standardized instrument and protocols.

HSAG routinely analyzes and reports the data on a quarterly basis for approximately 4,000 hospitals participating in HCAHPS public reporting. HCAHPS results are publicly reported on the Hospital Compare Web site. HSAG continues to enhance the HCAHPS Quality Assurance Guidelines, which are currently in their fifth edition. The use of HCAHPS data has been linked to pay for reporting of acute care hospitals.

MEDICARE HEALTH OUTCOMES SURVEY (HOS)

HSAG has played an integral role in the Medicare Health Outcomes Survey (HOS) project since its national implementation in 1998. HSAG has been CMS' data analysis, dissemination, education, and applied research contractor for the Medicare HOS program since 1998. Key tasks in HSAG's scopes of work continue to include annual data cleaning, analysis and dissemination; education and outreach; maintenance of the HOS Web site (www.hosonline.org); technical program support and assistance; and ad hoc analyses. The Medicare HOS is a longitudinal evaluation of the physical and mental health outcomes of beneficiaries enrolled in Medicare managed care plans nationwide, and is the first outcomes measure used in Medicare managed care. The HOS measure has been included in the Health Plan Employer Data and Information Set (HEDIS®) performance measures sponsored by the National Committee for Quality Assurance (NCQA) since 1998. The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. All managed care plans with Medicare Advantage contracts must participate. Since 1998, more than 4.7 million Medicare beneficiaries have been surveyed, and HSAG has analyzed and reported the data on more than 2.6 million beneficiaries.

EXPERIENCE WITH PROVIDING TECHNICAL ASSISTANCE

HSAG has extensive experience in providing technical assistance to Medicaid managed care contractors, for both mandatory and optional EQR activities and other projects required by state Medicaid agencies. Specifically, HSAG has provided technical assistance for performance improvement projects, performance measures, compliance activities, quality assessment and performance improvement program development and evaluation, provider network adequacy analyses, program evaluation, performance measure database development and tracking, focused reviews, clinical and nonclinical care studies, cultural competency program development, avoidable emergency department utilization reduction activities, and other ad hoc technical assistance requests by states.

Staff/Team Experience and Qualifications

HSAG will call upon the necessary project staff resources to ensure that information provided to the BMS accurately and reliably summarizes the performance of each MCO in each quality management area and identifies areas for corrective action and performance improvement. As HSAG's Executive Director with project oversight for West Virginia, Bonnie Marsh will provide leadership to the project staff and ensure that the quality of all work performed by project staff members meets not only the contract requirements, but also captures the MCOs' performance in using sound methodologies.

Proposed Approach and Methodology

The HSAG team members associated with all projects under the BMS' requested scope of work have the knowledge, skills, and abilities commensurate with the needs and subject matter expertise required for each EQR activity task. To draw accurate and reliable conclusions regarding MCO performance for each of the EQR activities and identify areas of focus for

improvement efforts, staff members will approach each of the activities using the following core competencies:

KNOWLEDGE AND EXPERTISE

- Federal managed care regulations under the BBA—HSAG has had experience reviewing MCOs under these requirements since their implementation. Staff members have studied the preamble to the regulations to understand intent and applicability of each requirement, and HSAG initiates communication with the CMS policy office when unique situations arise that call for authoritative input.
- State Quality Strategy—HSAG project staff will review the State Quality Strategy as a first step in understanding the State's approach to assessing and improving quality in its managed care program and the priority needs and goals of health care for the population served.
- State contract with the MCOs—The staff will quickly become knowledgeable about the State's requirements of its managed care organizations, how the State has implemented regulations that allow State choice, and any unique features and requirements in the MCO contract.
- Best practices, emerging successful practices, and national norms of performance—Because of its broad exposure to performing EQR for many MCOs in numerous states across the nation, HSAG has developed a wealth of knowledge of the performance levels and practices of new as well as more seasoned MCOs, which operate within varying practice models and with differing quality priorities. Using this knowledge and experience, as well as keeping current with industry literature, HSAG brings to bear the most relevant and useful quality improvement practice ideas and resources to share with its EQRO states and their managed care organizations.
- Managed care principles—As described in HSAG's EQRO project team biographies, numerous staff members have significant direct experience in state-level or MCO-level positions, and they bring a deep understanding of the principles that provide the framework for managed care. HSAG staff members apply this knowledge and experience in conducting the EQR activities, identifying strengths and areas of weakness in the MCOs.
- Quality management and performance improvement—The cornerstone of knowledge and expertise that HSAG brings to its clients is quality management and performance improvement. Having extensive experience as both an EQRO and a QIO, HSAG will perform its EQRO project work for the West Virginia MHT program using the resources and wealth of experience gained in these roles and from continued learning and participation in formal and informal health quality networks.

SKILLS, ABILITIES, AND TECHNIQUES

HSAG staff members responsible for the EQR activities and related tasks will use well-honed skills in their approach to the project work, in order to fairly and accurately assess MCO performance, make conclusions about areas of needed improvement, and make recommendations. These skills, abilities, and techniques include:

- Comprehensive review and synthesis of information from multiple sources (e.g., policies, procedures, committee meeting minutes, quality and utilization reports and data, performance measure rates).
- Observation (viewing system demonstrations, processes, work flows, etc.).
- Interviews (nonthreatening engagement of MCO staff members in dialogue about organization policies and processes to confirm and validate documented practices and to further understand the MCO's operations).
- Record review (assessing actual practice against the requirements, for example, appeal and grievance processing files, delegation oversight review results, and credentialing records).
- Professional judgment (any serious or immediate concerns are brought to the forefront for reporting to BMS and to expedite corrective action).
- Time management and efficiencies (planning and preparation, use of secure electronic media when obtaining documents from MCOs).

HSAG staff members understand that compliance in written structure documents (e.g., policies, procedures) and "correct" answers to interview questions do not always translate to actual practice compliance and/or improved outcomes. Because of this, HSAG typically incorporates record/file review or review of other practice evidence into its assessment and evaluation.

HSAG reviewers are prepared for and are sensitive to how difficult it may be for some individuals participating in interviews and other audit processes, and are professional and nonjudgmental when delivering sometimes difficult messages about MCO performance assessment. HSAG brings ideas and recommendations to the discussion, along with practical advice about other managed care organizations' successes or innovative solutions when correcting similar problems or deficiencies. "On-the-spot" mini-technical assistance is often incorporated into the interview session to clarify and explain a requirement or its intent. The summarized assessment and evaluation information about each MCO's performance for a given EQR activity is backed by detailed reviewer working notes, which can be referenced for additional details if BMS inquires about a particular practice or finding.

HSAG's approach to compliance reviews was observed by a regional CMS representative who indicated that she had learned so much by observing our style of interviews. She went on to say how we clearly had command of the subject matter, put the health plan staff at ease, and were very professional in our responses, follow-up questions, and explanations to the staff. She also remarked about how well-prepared we were for each of the reviews and that it was clear that a lot of planning and pre-review had taken place.

2.4.8 HSAG's Plan to Develop a Detailed Technical Report

2.4.8	The Vendor should propose a plan to develop a detailed technical report that describes the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO. The report includes all elements as required by 42 CFR §438.358 and does not disclose the identity of any individual patient.

Experience With Similar Projects

HSAG has acquired extensive experience in producing annual external quality review (EQR) technical reports since the implementation of this requirement of the Balanced Budget Act (BBA) of 1997. As the contracted EQRO, HSAG produces annual technical reports for Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, and Vermont.

Based on the characteristics and structure of each state's managed care model, HSAG has experience preparing one or more technical reports annually for these states; e.g., one for the state's managed care organizations (MCOs) and one for its mental health prepaid inpatient health plans (PIHPs), or one for a state's primary and acute population and a separate report for its aged/disabled population receiving long term services and supports. In addition, some states for which HSAG functions as the EQRO have requested plan-specific annual technical reports along with an overall, statewide report. HSAG refines its approach according to the specific needs and requests of the state, and is flexible and capable of approaching this task as the BMS has outlined.

Since technical reports are an annually required state deliverable to CMS and frequently are also made public to a variety of stakeholders, HSAG recognizes how critical it is for the EQRO to produce reports that address all CMS-required technical elements and provide information in sufficient detail. HSAG has significant experience and familiarity with CMS' *External Quality Review Toolkit for State Medicaid Agencies* that discusses, in part, the use of the state's Quality Strategy in developing the technical report, and collaborates with states to ensure the information provided in the technical report provides an assessment of the state's progress in meeting the overall state Quality Strategy goals and objectives. HSAG also understands how important it is to organize and write the reports in a way that can be easily understood by a variety of audiences and stakeholders, some of which may not have detailed knowledge and familiarity with the EQR activities and reporting requirements. In writing these reports, HSAG has experience working individually with each state to meet specific needs and to target specific audiences (e.g., legislators, the general public, health care providers, and consumers) and to present results in a useful and understandable way.

HSAG's annual reports of EQR results have been well-received by CMS. The following is a quote from CMS based on an evaluation of HSAG's technical report produced for one state client:

In addition to meeting CMS regulation requirements at 42 CFR 438.364, HSAG went above and beyond the requirements to produce a very professional and useful technical report.

HSAG is committed to providing reports to BMS that are easy to understand, timely, accurate, and meaningful, as well as informative, useful for BMS in its planning and quality improvement initiatives, and able to withstand the rigors of scientific review. One of HSAG's most valued and recognized attributes is its willingness and ability to customize reports and provide its state Medicaid agency clients with the format and writing style they prefer, affording a high level of sensitivity to, and value for, the intended audiences. HSAG provides to its EQRO clients examples of different technical report models for organizing and presenting the CMS-required information and data, but the final choice remains with the client. HSAG will work collaboratively with BMS to ensure that the format, content, writing style, and organization of the annual technical report meet BMS' requirements and preferences and that the CMS technical requirements for the report identified in 42 CFR 438.364 are met. In developing the technical report, HSAG ensures that the identity of any individual or patient is not disclosed.

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is Executive Director, State & Corporate Services Division for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debra Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work, contract deliverables, and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which time she reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Before joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Wendy Talbot, MPH, CHCA, is an Associate Director of Audits at HSAG and is responsible for the oversight and management of HSAG's NCQA HEDIS® Compliance Audit program as well as the Validation of Performance Measures activities for its EQRO contracts. Prior to her appointment to her current position, Ms. Talbot served as the Arkansas project manager, overseeing the day-to-day contract activities for HSAG's Arkansas data mining and program evaluation contract. She was also a project manager within the Audit Department, where she was responsible for support of the HEDIS audit program and all performance measure validation activities, including communicating with health plans, preparing agendas and scheduling and conducting site visits, reviewing the systems capabilities tools completed by the health plans, reviewing programming logic and output files, and compiling audit results into a final audit reports. Ms. Talbot is an NCQA-Certified HEDIS Compliance Auditor, and she is skilled in primary source verification of eligible population and numerator files, ensuring algorithmic compliance, and assessing bias using NCQA and CMS techniques and protocols.

Her previous roles at HSAG included project coordinator for performance improvement projects, performing validation of physical and behavioral health PIPs, and participating on external

quality review and compliance audits of Michigan mental health plans. She also served as a health care analyst with HSAG's Federal Division, providing analytic support for the CMS 7th Scope of Work quality improvement organization (QIO) contract and analyzing and reporting on ambulatory care and inpatient data, including mammography, diabetes, and immunizations.

Ms. Talbot has more than seven years of experience in epidemiology, data analysis and management, and health care/disease program management with state Medicare/Medicaid programs. She holds a Bachelor of Science degree in Health Sciences from the University of Nevada at Reno and a Master of Public Health degree from the University of Arizona, with emphasis in epidemiology.

Christi Melendez, RN, **CPHQ,** is the Associate Director of Quality Improvement Projects at HSAG and is responsible for leading the plan-specific, small-group, and collaborative PIP validation activities and tasks performed by the HSAG PIP Validation Team. Ms. Melendez has been with the company since 2001. She has more than 20 years of nursing experience in the clinical and home health settings, including case management and medical record reviews. In her current role, she works closely with the PIPs manager to validate health plan performance improvement projects by assessing the implications on the validity and reliability of the PIP findings. Ms. Melendez is responsible for providing technical assistance and training to states, as needed. In addition, she is also an RN abstractor/coordinator, performing review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She has assisted in the training of other RN abstractors and has provided on-site medical reviews for HEDIS auditing.

Ms. Melendez's prior experience includes 14 years of case management of long-term, chronically ill children, maternity and pediatric patients, and home health infusion patients. She was responsible for preparing quality assurance and treatment plans as well as performing medical record/documentation audits. She was actively involved in performance improvement activities.

Ms. Melendez is a Registered Nurse with an Associate of Science Degree in Nursing from Cypress College in California. She recently became a Certified Professional in Healthcare Quality (CPHQ).

Diane Christensen, LPC, is a Director, EQRO Services with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for the division's projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Masters of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Tom Miller, MA, is Executive Director, Research and Analysis Team, and has been with HSAG since December 2003. In his current role, Mr. Miller is responsible for oversight of all State & Corporate Services Division analysis activities and staff, including coordinating all HSAG analytic activities, implementing quality control processes, and training and oversight of State & Corporate analysts. Mr. Miller has more than 10 years of experience performing statistical analysis in the health care setting, including Medicaid managed care, pharmacy benefit management, disease management, and claims processing. He has extensive experience managing retrospective and survey research studies and encounter data validation studies involving the coordination of internal and external customers. Mr. Miller has worked with NCQA/QISMIC Accreditation Standards and HEDIS performance measures (including work with CAHPS). He has performed highly technical data manipulation/analysis to render meaningful interpretations, and to translate quantitative and qualitative research into operational goals and standards and improvement activities.

As head of the Analysis Team, Mr. Miller provides research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytical staff. He has been involved in designing and executing numerous focused studies, including evaluations of perinatal care, asthma management, lead screening, adolescent health care, and childhood immunizations in Ohio; perinatal care, asthma management, preventive services for persons with disabilities in Colorado; and EPSDT services for school-aged children in Michigan. Mr. Miller has also been involved in conducting encounter data validation activities for physical health programs in Hawaii, Ohio, and Tennessee; and for prepaid mental health plans in Utah. Additionally, Mr. Miller has worked on a variety of other projects, including case management reviews in Arizona and Ohio, HEDIS reporting in Florida, Ohio, and Michigan, evaluation of provider networks and benefit delivery in Tennessee and Nevada, Medicaid provider surveys in Colorado, and coordination of compliance audit sampling activities. He acts as a SAS and GeoAccess expert resource for the Research and Analysis Team.

Mr. Miller holds a Bachelor of Science Degree in Sociology and Psychology from Northern

Arizona University and a Master of Arts Degree in Sociology from the University of Cincinnati. He is a member of the AcademyHealth organization.

Proposed Approach and Methodology

Annually, HSAG will produce and deliver to BMS an EQR technical report that addresses all of the State's requirements. HSAG will ensure the report is provided to BMS no later than the deliverable due date agreed upon with BMS.

The report will provide BMS with a clear description of its MCOs' performance in providing West Virginia's Medicaid recipients with services that meet the requirements of the federal Medicaid managed care regulations, BMS' contracts with the MCOs, BMS' quality strategy, and any related policies/procedures. The annual technical report will include the following information for each EQR activity conducted in accordance with 42 CFR 438.358:

- Objectives of the activity.
- Technical methods of data collection and analysis.
- Description of the data obtained.
- Conclusions drawn from the data.

The report will also include detailed information on the results of each of the three mandatory EQR activities conducted, as well as any optional or additional activities conducted by the State or the EQRO that lend information to the overall assessment and evaluation of quality, timeliness, and access to care/utilization of care and services provided by the MCOs. HSAG understands that information from the following annual EQR activities, at a minimum, will be used in the independent evaluation and assessment: review and validation of performance improvement projects conducted by the MCOs, validation of performance measures calculated by the MCOs, review of compliance with State-specific and federal standards and requirements (including a discussion of any standards that were "deemed" compliant under 42 CFR 438.360), and focused review of unique MCO requirements and activities. This evaluation will include the following, at a minimum:

1. An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to care/utilization of health care services furnished to its Medicaid recipients. The assessments will be based on the following definitions of quality, access, and timeliness:

   Quality—CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[3]

[3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 3, October 1, 2005.

Timeliness—NCQA defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[4] It further discusses that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require a timely response by the MCO; e.g., processing expedited member appeals and providing timely follow-up care.

Access—In the preamble to the BBA Rules and Regulations, CMS discusses access and availability of services to Medicaid enrollees as "the degree to which MCOs/PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP."[5]

2. Recommendations for improving the quality and timeliness of, and access to, health care services furnished by the MCO. Based on the overall assessment of each MCO's provision of quality, timely, and accessible services, HSAG uses its detailed knowledge of each MCO's strengths and weaknesses to fashion plan-specific recommendations for improvement. HSAG draws upon it data and experiences from similar reviews across the nation and from its large bank of knowledge of emerging and best practices, and makes specific and actionable recommendations to the State and MCOs for quality improvement. In addition, any statewide areas of opportunity are identified and recommendations for collaborative improvement efforts are made to efficiently and effectively address any systemwide areas of weak performance. These are also typically identified as areas for targeted technical assistance.
3. An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's external quality review. HSAG examines prior corrective or improvement actions that each MCO has implemented based on the prior year's EQR activity results, and it determines the effectiveness of the actions in resolving the identified deficiency. HSAG has observed that even well-planned corrective actions implemented by MCOs do not always result in sustained improvement, and the MCOs often need to re-evaluate and analyze the root causes of the deficiency in order to have lasting results.

To ensure that HSAG's annual technical report meets the highest expectations for the data and information contained within it, and that it conforms to both CMS' and BMS' requirements, HSAG is diligent and methodical in its approach when preparing the report. As described in the work plan, the first step will be for HSAG and BMS to reach agreements as to the preferred approach to the report, which will define the high-level organization of the report and the writing and presentation styles that will be most responsive to the intended audiences and BMS' information needs. Throughout each of the steps that HSAG will follow in preparing the report, regular communication and coordination with BMS will be initiated as needed to clarify

[4] National Committee on Quality Assurance. 2010 Accreditation Standards and Guidelines for Health Plans.
[5] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register,* Vol. 67, No. 115, June 14, 2002.

expectations and reach agreements. HSAG does this in a planned and thoughtful manner, sensitive to the workloads and other priorities of the BMS staff members, and is flexible and responsive to changes in the needs and timelines.

The following are the steps HSAG will take to produce a professional and informative annual technical report for BMS:

DEVELOP THE APPROACH

Through planned phone calls or face-to-face meetings with BMS, HSAG will seek to gain a clear understanding of BMS' goals, expectations about timelines and review periods, intended audience for the report, level of information detail sought, and any other preferences and requirements for the technical report. Based on this understanding, HSAG will draft a timeline and report outline that responds to BMS' needs. Once review and feedback are provided by BMS, HSAG will adjust the outline and timeline. The approved outline will be followed to create a report template for the writers' use in developing the technical report content. The project director will be responsible for convening a team meeting to relay information about the goals and expectations, writing style decisions, intended audience, and report outline to the technical report team. The Reports Department will then create a customized report template for use by all writers and contributors to the technical report.

COMPILE THE METHODOLOGICAL DESCRIPTIONS FOR EACH EQR ACTIVITY

HSAG's methodologies for conducting the BMS-required EQR activities are consistent with the CMS published protocols for conducting EQR activities. The specific steps and activities performed for each of the quality review activities that HSAG conducts will be clearly described in the technical report.

In addition, HSAG subject matter experts for each of the mandatory EQR activities will summarize the methodology that was used to aggregate and analyze data and to draw conclusions about quality, timeliness, and access to care furnished by the MCOs. In selecting, defining, and evaluating the appropriateness of a selected methodology, HSAG considers key factors such as any weighting issues.

COMPILE AND ANALYZE THE DATA FROM ALL EQR ACTIVITIES

The report will include the data HSAG obtained and upon which it based its findings, conclusions, and recommendations. In order to ensure that the data are complete and accurate, HSAG's Research and Analysis Team will determine how the data were collected, by whom, and whether the data were accurately defined and described. HSAG understands that the data must be valid and must capture the key and meaningful aspects of care in order for conclusions to be drawn. HSAG's experienced team of analysts follow strict and current industry standards in its statistical practices for validating data, assessing:

- The methodologies and tools HSAG used when conducting each of the EQR activities to determine the MCO's performance.
- The data and results obtained for each of the activities (i.e., review of compliance and unique MCO requirements, validation and review of PIPs, and validation of performance measures),

which will vary considerably in terms of type, format, and the most appropriate methods for validating.

At a high level, and as defined by the BBA, "validation" is the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. The report will include a description of HSAG's processes for ensuring that it used appropriate statistical and methodological guidelines to arrive at valid, reliable, and accurate conclusions about the MCOs' performance in providing quality, timely, and accessible services to Medicaid recipients.

DRAFT THE TECHNICAL REPORT

The narrative discussion of the results of each EQR activity will include conclusions drawn from the data and identification of the MCOs' strengths and weaknesses in providing quality, timely, and accessible care and services. Subject matter experts will provide the content for this report based on their hands-on experience conducting the EQR activities for the West Virginia MCOs. Through its significant experience in conducting the EQR activities, HSAG has established, maintains, and continually updates a large database of Medicaid health plan data. Having ready access to these data, HSAG is able to provide meaningful and credible conclusions about MCO performance results using comparisons to both regional and national benchmarks.

The HSAG Reports Department will support the development of the report with technical writers and editors to ensure clarity and consistency in the format and presentation of the report. HSAG's analysts and its editorial staff members collaborate and are creative in designing innovative, meaningful, and state-of-the-industry ways to present data and the associated conclusions derived from the data so that all material can be easily understood by a variety of audiences. HSAG capitalizes on the power of presenting data in a way that is immediately visually informative and meaningful, including use of color graphs, charts, and flow diagrams and other design elements to present a snapshot of performance. Working with HSAG's professional editing staff members, HSAG's analysts use state-of-the-industry tools (e.g., Statistical Analysis Software [SAS]) to generate graphs that enhance the visual presentation of quantitative information.

HSAG takes very seriously its obligation and role as an independent, unbiased EQRO when evaluating and reporting on MCO performance. As such, it recognizes the importance of accuracy, precision, and quality control at multiple points during report production, in addition to ensuring the clarity and readability of its written deliverables. To ensure that the annual technical report meets the highest professional standards for accuracy of content, writing style, and readability, all staff members involved in preparing the reports (i.e., analysts, writers and editors, report production staff, and managers/directors) will be involved in the quality assurance and control processes. The reports will be read by technical writers, editors, and other readers to provide a second level of review for accuracy, completeness, and readability, and to provide objective perspectives and feedback on the reports prior to sending the draft to BMS for its review. HSAG welcomes and values candid feedback on its draft reports from its state clients.

FINALIZE THE TECHNICAL REPORT

After BMS' review and comment on the draft technical report, HSAG will discuss and clarify any areas of feedback with BMS and then revise the report as indicated. Once approval is obtained, HSAG will prepare the final report and submit it to BMS in the formats (electronic, CD, printed) and number of copies requested.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD	West Virginia Project Director	Debra Chotkevys, DHA, MBA
PMV	Assoc. Director, Audits	Wendy Talbot, MPH, CHCA
PIP	Assoc. Director, PIPs	Christi Melendez, RN, CPHQ
CR	Director, Compliance Reviewer	Diane Christensen, MC, LPC
RA	Dir., Research and Analysis Team	Tom Miller, MA
DRD	Director, Reports Department	Cheryn Wall, EdD

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Develop Approach			
Discuss with BMS the goals, intended audience, and timeline for the technical report.	OPD, WVPD	7/3/12	8/3/12
Develop draft timeline, table of contents, and proposed outline for the technical report and discuss with BMS. Obtain feedback, make adjustments, and finalize when approved.	WVPD, DRD	8/3/12	8/31/12
Prepare report template according to approved outline, and distribute report sections to EQR team members. Discuss and clarify approach, timeline, BMS goals, and intended audience with assigned team.	OPD, WVPD, PIP, PMV, CR, RA, DRD	9/4/12	10/1/12
Compile Methodology Descriptions			
Compile and summarize methodology for obtaining, aggregating, and analyzing all available EQR activity data.	WVPD, PIP, PMV, CR, RA	11/2/12	11/16/12
Compile and summarize methodology for identifying issues and deriving conclusions about MCO quality, timeliness, and access to care using EQR activity data and other data sources.	WVPD, PIP, PMV, CR, RA	11/19/12	11/30/12
Compile and Analyze Data			
Compile, analyze, and summarize EQR activity data across MCOs, and display in approved data presentation style(s).	RA	12/3/12	1/2/13
Validate EQR activity results data against source documents.	RA	1/2/13	1/7/13
Provide current benchmark data fields based on approved methodology and approach, and derive preliminary conclusions for each MCO and each EQR activity.	RA, WVPD, PIP, PMV, CR	1/7/13	1/14/13
Draft Technical Report			
Draft narrative discussion of the manner in which all available EQR activity data were used to derive conclusions for each MCO and for each EQR activity.	WVPD, PIP, PMV, CR	1/14/13	2/11/13
Draft narrative discussion of the manner in which all available	WVPD, PIP, PMV,	1/14/13	2/11/13

Task and Sub-Task/Description	Responsibility	Start Date	End Date
EQR activity data were used to identify issues and derive conclusions about quality, timeliness, and access to care. Include in this discussion how the State's Quality Strategy was used in this assessment.	CR		
Perform peer and technical review of draft technical report.	ED, WVPD, DRD	2/11/13	2/28/13
Provide draft report to BMS for review and comment. Discuss and respond to any questions or feedback, and incorporate changes into report as appropriate.	ED, WVPD	3/1/13	3/22/13
Finalize Technical Report			
Perform final peer and technical review of technical report. Produce electronic and printed/bound copies as agreed.	ED. WVPD, DRD	3/22/13	3/28/13
Deliver final annual technical report to BMS.	WVPD	3/29/13	3/29/13

2.4.9 HSAG's Plan to Develop Annual Plan-Specific Reports

2.4.9	The Vendor should propose a plan to develop annual plan-specific reports that include all elements required by 42 CFR §438.364, including an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients, recommendations for improving the quality of health care services furnished by each MCO based on the evaluation of the EQR activities, an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the Vendor during the previous year's EQR, and assessment of the extent to which corrective actions recommended by the EQR have been implemented and the results of these corrective actions.

Experience With Similar Projects

HSAG has acquired extensive experience in producing annual external quality review (EQR) activity reports, including plan-specific reports, since the implementation of the requirements of the Balanced Budget Act (BBA) of 1997. As the contracted EQRO for numerous states, HSAG produces EQR activity-specific reports of results, which are also plan-specific, for the mandatory and optional activities conducted in Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, and Vermont. In addition, for the State of California HSAG produces annual plan-specific performance evaluation reports for the 24 managed care plans. These reports include all of the elements that BMS requires and as described in the Code of Federal Regulations (CFR), 42 CFR §438.364.

HSAG recognizes how critical it is for the EQRO to produce reports that address required technical elements and draw logical and scientifically supported conclusions regarding MCO performance for each of the EQR activities and for identification of areas needing improvement. HSAG also understands how important it is to organize and write the reports in a way that can be easily understood by a variety of audiences, some of which may not have detailed knowledge and familiarity with the EQR activities and reporting requirements.

HSAG's reports of specific MCO performance across all EQR activities are factual and fair, and they present a summary and analysis of evaluation results that derive conclusions about the organization's performance, providing actionable recommendations for further quality improvement. In its assessment, HSAG highlights MCO activities that are unique, effective in demonstrating improvements in care or service, generate high satisfaction survey results, and further the Quality Strategy.

The following is a comment HSAG received from one of its EQRO clients:

> ***(I wanted)…to tell you how great a job I think everyone did on the Technical Report. It is well written, follows good logic, is easy to read and includes everything CMS has asked for.***

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is Executive Director, State & Corporate Services Division, for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debra Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work, contract deliverables, and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which time she reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Before joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies,

on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Wendy Talbot, MPH, CHCA, is an Associate Director of Audits at HSAG and is responsible for the oversight and management of HSAG's NCQA HEDIS® Compliance Audit program as well as the Validation of Performance Measures activities for its EQRO contracts. Prior to her appointment to her current position, Ms. Talbot served as the Arkansas project manager, overseeing the day-to-day contract activities for HSAG's Arkansas data mining and program evaluation contract. She was also a project manager within the Audit Department, where she was responsible for support of the HEDIS audit program and all performance measure validation activities, including communicating with health plans, preparing agendas and scheduling and conducting site visits, reviewing the systems capabilities tools completed by the health plans, reviewing programming logic and output files, and compiling audit results into a final audit reports. Ms. Talbot is an NCQA-Certified HEDIS Compliance Auditor, and she is skilled in primary source verification of eligible population and numerator files, ensuring algorithmic compliance, and assessing bias using NCQA and CMS techniques and protocols.

Her previous roles at HSAG included project coordinator for performance improvement projects, performing validation of physical and behavioral health PIPs and participating on external quality review and compliance audits of Michigan mental health plans. She also served as a health care analyst with HSAG's Federal Division, providing analytic support for the CMS 7th Scope of Work quality improvement organization (QIO) contract and analyzing and reporting on ambulatory care and inpatient data, including mammography, diabetes, and immunizations.

Ms. Talbot has more than seven years of experience in epidemiology, data analysis and management, and health care/disease program management with state Medicare/Medicaid programs. She holds a Bachelor of Science Degree in Health Sciences from the University of Nevada at Reno and a Master of Public Health Degree from the University of Arizona, with emphasis in epidemiology.

Christi Melendez, RN, **CPHQ** is Associate Director of Quality Improvement Projects at HSAG and is responsible for leading the plan-specific, small-group, and collaborative PIP validation activities and tasks performed by the HSAG PIP Validation Team. Ms. Melendez has been with the company since 2001. She has more than 20 years of nursing experience in the clinical and home health settings, including case management and medical record reviews. In her current role, she works closely with the PIPs manager to validate health plan performance improvement

projects by assessing the implications on the validity and reliability of the PIP findings. Ms. Melendez is responsible for providing technical assistance and training to states, as needed. In addition, she is also an RN abstractor/coordinator, performing review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She has assisted in the training of other RN abstractors, and has provided on-site medical reviews for HEDIS auditing.

Ms. Melendez's prior experience includes 14 years of case management of long-term, chronically ill children, maternity and pediatric patients, and home health infusion patients. She was responsible for preparing quality assurance and treatment plans as well as performing medical record/documentation audits. She was actively involved in performance improvement activities.

Ms. Melendez is a Registered Nurse with an Associate of Science in Nursing Degree from Cypress College in California. She recently became a Certified Professional in Healthcare Quality (CPHQ).

Diane Christensen, LPC, is a Director, EQRO Services, with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for designated division projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Masters of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Tom Miller, MA, is **Executive Director, Research and Analysis Team** and has been with HSAG since December 2003. In his current, Mr. Miller is responsible for oversight of all State & Corporate Services Division analysis activities and staff, including coordinating all HSAG analytic activities, implementing quality control processes, and training and oversight of State & Corporate analysts. Mr. Miller has more than 10 years of experience performing statistical analysis in the health care setting, including Medicaid managed care, pharmacy benefit management, disease management, and claims processing. He has extensive experience managing retrospective and survey research studies and encounter data validation studies involving the coordination of internal and external customers. Mr. Miller has worked with NCQA/QISMIC Accreditation Standards and HEDIS performance measures (including work with CAHPS). He has performed highly technical data manipulation/analysis to render meaningful interpretations, and to translate quantitative and qualitative research into operational goals and standards and improvement activities.

As head of the Research and Analysis Team, Mr. Miller provides research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytical staff. He has been involved in designing and executing numerous focused studies including evaluations of perinatal care, asthma management, lead screening, adolescent health care, and childhood immunizations in Ohio; perinatal care, asthma management, preventive services for persons with disabilities in Colorado; and EPSDT services for school-aged children in Michigan. Mr. Miller has also been involved in conducting encounter data validation activities for physical health programs in Hawaii, Ohio, and Tennessee; and for prepaid mental health plans in Utah. Additionally, Mr. Miller has worked on a variety of other projects, including case management reviews in Arizona and Ohio, HEDIS reporting in Florida, Ohio, and Michigan, evaluation of provider networks and benefit delivery in Tennessee and Nevada, Medicaid provider surveys in Colorado, and coordination of compliance audit sampling activities. He acts as a SAS and GeoAccess expert resource for the Research and Analysis Team.

Mr. Miller holds a Bachelor of Science Degree in Sociology and Psychology from Northern Arizona University and a Master of Arts Degree in Sociology from the University of Cincinnati He is a member of the AcademyHealth organization.

Proposed Approach and Methodology

HSAG is well prepared to provide BMS with annual plan-specific reports that assess each MCO's performance across external quality review activities—validation and review of PIPs, validation of performance measures, review of compliance with State and federal standards, review of unique MCO activities—and any additional quality improvement activities conducted by the State and the MCOs that may include consumer and provider satisfaction surveys, focused studies, and other quality review activities. These annual reports will provide BMS with an objective overall picture of each MCO's performance in each quality management area and will identify MCO strengths as well as areas for corrective action and performance improvement (weaknesses) with respect to quality, timeliness, and access to care/utilization of the care and services the MCO provides to its Medicaid recipients. For each MCO, the report will serve as an

annual "report card" and an independent assessment of each plan's performance in the domains of quality, timeliness, and utilization of and access to services. In addition, the MCOs will be encouraged to incorporate these findings and recommendations into their organizations' quality assessment and performance improvement (QAPI) annual evaluations and to develop their QAPI plans for the following year. The reports will include all required elements and utilize aggregate data, thus not disclosing the identity of any individual Medicaid recipient.

HSAG's approach and objective relative to MCO performance evaluation will be to develop a comprehensive profile of each MCO primarily using data and EQR activity results collected by HSAG and BMS. The process for each MCO-specific assessment and evaluation will involve extensive analysis of the existing data from EQR activities, analysis of trends over time for each MCO, and determination of the MCO's progress toward correcting previous deficiencies and meeting the quality goals established by BMS. Recommendations will be made based on the analyses. Technical assistance and other possible resource needs will be identified. HSAG will work closely with BMS to ensure that all quality indicators and performance measures that are relevant to the Mountain Health Trust Medicaid managed care program population and important for BMS to meet its quality strategy goals are included in the assessment process.

In order to meet the requirements as outlined in this request for proposals, HSAG will structure the plan-specific reports to clearly address all required report components. The reports will be developed to be fully compliant with all federal and BMS requirements, and will include:

- A description of the manner in which data from all EQR activities were aggregated and analyzed; i.e., methodologies used.
- A description of how conclusions were drawn as to the quality, timeliness, and access to care furnished by each MCO.
- A listing of objectives for each EQR activity conducted.
- The technical methods HSAG used to collect and analyze the data.
- A description of the data obtained; e.g., relevant time periods and data sources.
- Conclusions drawn from the data.
- An assessment of the strengths and weaknesses of each MCO with respect to the quality, timeliness, and access to services furnished to its Medicaid recipients.
- MCO-specific recommendations to address any identified improvement opportunities.
- An assessment of the degree to which each MCO was effective in addressing quality improvement recommendations made by the EQRO in the prior year.

The HSAG team will also take necessary steps to ensure that the information presented in the individual MCO reports is consistent with other summary reports and information provided to BMS, such as the annual technical report and comparative MCO report, if using the same review periods and data sources.

The following steps outline HSAG's approach to developing the annual plan-specific reports:

DEVELOP THE APPROACH AND OUTLINE FOR THE ANNUAL PLAN-SPECIFIC REPORTS

HSAG is committed to providing BMS with reports that provide information in a manner and format that not only meet the requirements, but also meet the State's goals and are geared toward the intended audience(s). The project executive and director will discuss with BMS its goals and audience for the reports and ensure this information is relayed to all team members responsible for this project. The HSAG EQR activity team leaders will assist with developing a draft outline, structured to address each component of MCO performance, including the results from validation of performance measures, review and validation of PIPs, reviews of compliance and unique MCO activities, the MCOs' follow-up corrective actions in response to prior EQRO recommendations, and any other quality activity data HSAG may obtain from BMS and the MCOs. The proposed report outline will provide BMS with a high-level description of the content that will be displayed in each section of the reports. The draft outline will be submitted to BMS for review and feedback. HSAG will incorporate BMS' feedback into the draft outline and prepare a final report template version for use by the HSAG team members who will prepare the reports.

COMPILE AND ANALYZE ALL QUALITY REVIEW DATA

HSAG will compile all results of EQR activities conducted within the previous 12-month period (within a three year period for compliance review results) and work with BMS to identify and obtain any additional quality improvement data that may contribute valuable information to the reports. This may include, for example, results of focused studies or recent consumer or provider satisfaction surveys conducted by or on behalf of the MCOs. It may also include required corrective action plans from the prior year and any re-evaluations of MCO performance following implementation of those plans.

HSAG will prepare a data set that contains the results from all EQR activities, as well as any related quality monitoring activity information shared by BMS or, if applicable, the MCOs. HSAG will review the type and quantity of data available for each measure, indicator, and activity. During this stage of the review, the validity and reliability of the data will be determined. EQR activity team leaders will also research and compile the most current and relevant benchmarking data fields for each measure or activity, per the agreed-upon methodology, for purposes of evaluating each MCO's performance and comparing it to national or State averages/benchmarks or for trending over time. This is an important step in evaluating performance and progress and for drawing meaningful conclusions about quality.

HSAG will analyze the data for each activity or measure and use graphs and other visual presentations to display MCO performance along with comparisons and trends. The MCO's overall performance in each of the dimensions (quality, timeliness, and access) will be evaluated for areas of strength and weakness. Drawing from its breadth of experience and exposure to managed care organizations across the nation, HSAG will offer recommendations for improvement and cite relevant best and emerging practices for addressing any identified deficits or areas of weak performance. Finally, an assessment will be made of the MCO's effectiveness in addressing any recommendations made in the prior year by the EQRO. This may include review and evaluation of formal corrective action plans implemented during the year and the

outcomes of those action plans.

PREPARE DRAFT PLAN-SPECIFIC REPORTS

HSAG will annually prepare the draft plan-specific reports using a collaborative and integrated team approach aimed at identifying themes or trends in performance across the different data sets and EQR activities. HSAG has expertise in looking beyond "paper compliance," typically found in structure and process reviews, and it also evaluates actual outcomes of care. In this way, HSAG assists managed care organizations to "connect the dots" between, for example, their disease management programs, practice guidelines, member outreach materials and processes, availability of specialists in their network, and resulting HEDIS measure rates for certain chronic conditions. It is HSAG's primary goal to provide accurate and meaningful information to BMS and each MCO that can be used to trigger real, measureable, and sustainable improvement in care and service delivery.

To further ensure accuracy, consistency, and clarity of the reported information, HSAG uses rigorous processes of peer and technical review prior to releasing the draft reports to the State. Once in draft form, HSAG will allow sufficient time for BMS' review and comment on the draft reports. If desired by BMS, HSAG will also plan for and facilitate a review and comment period by the respective MCOs prior to finalizing the reports.

PREPARE FINAL PLAN-SPECIFIC REPORTS

Any needed report changes based on feedback from BMS (and the MCOs, if their review is requested) will be incorporated into the final reports in a timely fashion. HSAG will manage this process to ensure that the timeliness of the final reports will not be adversely impacted. The final-plan specific reports will be submitted to BMS and the respective MCOs by the required due date each year, in the format and quantity of copies requested.

The reports produced by HSAG bring value to state clients and their managed care organizations, and are used to initiate quality improvement efforts, institute changes in strategy, and reward and celebrate successes and improvements. HSAG will work closely with BMS and the MCOs to produce meaningful information that is presented clearly and accurately, and HSAG will be a partner in the quality improvement efforts for the State of West Virginia.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD	West Virginia Project Director	Debra Chotkevys, DHA, MBA
PMV	Assoc. Director, Audits	Wendy Talbot, MPH, CHCA
PIP	Assoc. Director, PIPs	Christi Melendez, RN, CPHQ
CR	Director, Compliance Reviewer	Diane Christensen, MC, LPC
RA	Dir., Research and Analysis Team	Tom Miller, MA
DRD	Director, Reports Department	Cheryn Wall, EdD

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Develop Approach			
Discuss with BMS the goals, intended audience, and timeline for the plan-specific reports.	OPD, WVPD	7/3/12	8/3/12
Develop proposed data presentation style(s) and obtain BMS feedback and approval.	WVPD, RA, DRD	8/3/12	8/31/12
Develop draft table of contents and proposed outline for the plan-specific reports and discuss with BMS. Obtain feedback, make adjustments, and finalize when approved.	WVPD, DRD	9/4/12	10/1/12
Prepare report templates according to approved outline and distribute report sections to EQR team members. Discuss and clarify approach, timeline, BMS goals, and intended audience with assigned team.	OPD, WVPD, PIP, PMV, CR, RA, DRD	10/1/12	11/2/12
Compile and Analyze Data			
Compile, analyze, and summarize EQR activity data for each MCO, and display in approved data presentation style.	RA	12/3/12	1/2/13
Validate EQR activity results data against source documents.	RA	1/2/13	1/7/13
Provide current comparative data fields as appropriate (e.g., national benchmarks, State quality goals, prior year's results) based on approved methodology and approach, and derive preliminary conclusions for each MCO for each EQR activity.	RA, WVPD, PIP, PMV, CR	1/7/13	1/14/13
Draft Plan Specific Reports			
Draft narrative discussion of comparisons and conclusions for each MCO for each EQR activity. Include plan-specific strengths and weaknesses regarding quality, timeliness, and access to services, recommendations for improvement, and an assessment of the results and effectiveness of each MCO in successfully addressing EQRO recommendation the prior year.	WVPD, PIP, PMV, CR	1/14/13	2/11/13
Perform peer and technical review of draft reports.	ED, WVPD, DRD	2/11/13	2/28/13
Provide draft reports to BMS for review and comment. Discuss and respond to any questions or feedback, and incorporate changes into report as appropriate. (At BMS' option, provide draft reports to each MCO for review and comment.)	ED, WVPD	3/1/13	3/22/13
Finalize Plan Specific Reports			
Perform final peer and technical review of plan-specific reports. Produce electronic and printed/bound copies as agreed.	ED. WVPD, DRD	3/22/13	3/28/13
Deliver final annual plan-specific reports to BMS and the respective MCOs.	WVPD	3/29/13	3/29/13

2.4.10 HSAG's Plan to Develop a Comparative MCO Report

2.4.10 The Vendor should propose a plan to develop a report to include comparative information about all MCOs. Vendor should provide a sample report; final format to be agreed upon by the Vendor and State.

Experience With Similar Projects

HSAG has extensive experience in producing annual external quality review (EQR) comparative reports as part of, or in addition to, the states' technical reports and has done so since the implementation of the federal managed care requirements. As the contracted EQRO, HSAG produces annual technical reports for Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, and Vermont. The majority of HSAG's state clients request that HSAG conduct a comparative analysis of their contracted MCOs and/or PIHPs and include this comparative assessment in the state's annual EQR technical report. These reports highlight and compare performance of health plans on EQR activities that include compliance monitoring, performance improvement projects, performance measures, and other quality measures assessed during a given year. As part of the comprehensive annual comparative assessment, each MCO's or PIHP's current performance is also compared with its prior performance in order to determine whether improvement is evident in health plan scores. With these various approaches, multi-dimensional comparisons can be performed—within and across the health plans, against national or local benchmarks and goals, and trending of statewide or plan-specific performance over time. HSAG refines its approach according to the specific needs and requests of each state, and is flexible and capable of approaching this task according to BMS' requirements and preferences for producing an annual comparative MCO report.

HSAG has extensive experience conducting comparative analyses of health plan performance across a variety of measures and against a variety of national benchmarks, state-specific goals, or averages. Understanding the importance of providing insightful, actionable, and detailed results, HSAG clearly presents findings so its clients can identify statewide trends and areas for improvement as well as evaluate the performance of individual health plans. Further, as appropriate, statistical testing is used to identify whether a health plan performs significantly better or worse than its peers.

To evaluate and compare health plan performance, HSAG has conducted numerous clinical and nonclinical focused studies in Colorado (e.g., adolescent well-care, perinatal care, asthma management, diabetes care, preventive services), Florida (adolescent well-care), and Ohio (e.g., lead screening, EPSDT services, case management, smoking cessation, childhood immunizations) in which plan performance across a spectrum of quality indicators was measured against peer performance as well as national and state-mandated standards. The results from these studies enabled HSAG to identify high and low performers in addition to targeting specific plan-based recommendations for improvement.

For the states of Arkansas, Colorado, Florida, Georgia, Hawaii, Michigan, Ohio, and Washington, HSAG also has considerable experience generating annual HEDIS® and CAHPS® rates from which comparative analyses are conducted to evaluate how health plans performed against statewide weighted averages, national benchmarks, and each other. In Michigan and Hawaii, HSAG has repeatedly used the results from these two activities to develop a *consumer guide* that allows Medicaid members to make informed decisions regarding their health plan enrollment choice based on the relative strengths and weaknesses of participating Medicaid health plans. In Ohio, HSAG has worked with the State to develop an online report repository that presents comparative plan performance across all Medicaid monitoring measures. This information is used to generate a semiannual report card. Moreover, HSAG has experience assessing and presenting comparative information for both traditional Medicaid populations (i.e., children and pregnant women) as well as long term care populations (i.e., aged, blind, and disabled). In some of HSAG's contracted states, these comparative reports are used as a kind of "report card" on plan performance that is available publicly and, importantly, to Medicaid recipients faced with choosing a health plan for their enrollment.

Additionally, HSAG has performed comparative analyses to evaluate the accuracy and completeness of submitted encounter data in Colorado, Georgia, Hawaii, Ohio, Tennessee, and Utah. Using a combination of on-site systems reviews, administrative data analyses, and medical record review, HSAG measured the quality of claims and encounter data elements among and across Medicaid health plans and presented evaluative results.

For the State of Arkansas, HSAG produces a professional, executive summary-level HEDIS report that highlights performance for the State's two primary Medicaid programs. Aggregate results are calculated on an annual basis and presented in five-year trends to facilitate comparisons between programs and illustrate performance improvement over time. Information in the report is designed for consumption by a diverse audience, including members, advocates, legislators, and other key stakeholders. An example of HSAG's work product for the State of Arkansas is available in the public domain at:

https://ardhs.sharepointsite.net/DMS%20Public/DMS%20Reports/HEDIS%20Measures/HSAG_HEDIS_2010.pdf

As another example of how HSAG has provided comparative analysis and information to a state Medicaid agency, attached as part of this RFP response is the State of Hawaii's annual technical report for 2011 (also available publicly on the State of Hawaii, Med-QUEST Division's Web site). The report—*2011 External Quality Review Report of Results for the QUEST and QUEST Expanded Access Health Plans*—contains *Health Plan Comparison by EQR Activity* as Section 4 of the report. In this section, HSAG presented comparisons of the EQR activity results for the five Medicaid health plans based on the state's preferences and requirements. For the compliance review, comparisons of the plans' scores were made for each performance standard (i.e., the structure and operation standards contained in 42 CFR 438, Subpart D) to the statewide average scores and to the other plans' scores. For the validated performance measures, comparisons of the plans' HEDIS 2010 rates to the corresponding national HEDIS benchmarks (that were used as the state's quality strategy targets) were made; in general, the State quality target was the national HEDIS 2010 Medicaid 75th percentile. In addition, HSAG rank-ordered the plans'

performance on the HEDIS measures within the two Medicaid programs (primary and acute program and long term care program). For their PIPs, the health plans were compared to each other based on the degree to which they successfully designed, implemented, and measured outcomes of their PIPs and, importantly, the degree to which they achieved and sustained statistically significant improvement as a result of each project. For the CAHPS (Child) survey, HSAG compared each plan's results to the statewide aggregate performance within the specific program, and to the 2010 NCQA national child Medicaid averages for each measure. Lastly, HSAG conducted a provider survey on a sample of the State of Hawaii's participating Medicaid providers (PCPs and specialists). Plan-specific results were aggregated, analyzed, and compared across plans and within each program, as there are no national benchmarks for this custom-designed survey.

In addition to Hawaii's technical report deliverable to CMS, HSAG assisted with the creation of consumer guides for the State of Hawaii using HEDIS and CAHPS measure results, as described previously. These guides were customized for consumer use in selecting a health plan for enrollment, and were developed to display both plan-specific results as well as statewide aggregate information. They are posted on the State's Web site, accessible at:

http://www.med-quest.us/ManagedCare/consumerguides.html

Staff/Team Experience and Qualifications

Bonnie Marsh, RN, BSN, MA is Executive Director, State & Corporate Services Division, for HSAG's EQRO contracts. For the West Virginia EQRO project, Ms. Marsh will provide executive oversight and expertise, and will have oversight of HSAG's West Virginia Project Lead, Debra Chotkevys. In her role as Executive Director, she has day-to-day oversight responsibility of all scopes of work and contract deliverables and is the primary contact for state Medicaid agencies. Ms. Marsh is responsible for the quality of all work performed by project staff members and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. She develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's Quality Strategy.

Ms. Marsh is a Registered Nurse with more than 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors. Ms. Marsh's experience includes behavioral health clinical supervision; quality and utilization management; grievance, appeal, and risk management; and member services and advocacy. Prior to joining HSAG, she managed the behavioral health benefit program for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, and was responsible for monitoring the delivery of behavioral health services by contracted managed care organizations and prepaid inpatient health plans, using the CMS Protocols for Determining Compliance with BBA requirements. She also participated in CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and CHIP programs.

Ms. Marsh received her RN diploma from St. Vincent Hospital School of Nursing, as well as a Bachelor of Science Degree in Nursing and a Master of Arts Degree in Organizational Management from the University of Phoenix.

Debra Chotkevys, DHA, is a Project Director for the State & Corporate Services Division at HSAG. Dr. Chotkevys will serve as the West Virginia Project Lead and as such will have day-to-day responsibility for all contract activities, deliverables, and be the primary contact between BMS and HSAG. She will be available between 8 a.m. and 5 p.m. Eastern Time, Monday through Friday, and will attend all quarterly meetings of the MHT Task Force. Dr. Chotkevys has more than 25 years of health care experience in physician credentialing and site reviews, medical record abstraction, and accreditation standards. She has been involved with external quality reviews for Medicaid managed care for the past 11 years, during which time she reviewed quality and operational standards. Currently, Dr. Chotkevys is involved in the external quality review activities in Nevada, Tennessee, and Florida. Her responsibilities include leading cross-functional teams, creating automated compliance evaluation tools to assess MCOs' performance, conducting compliance reviews of managed care compliance with state and federal standards, and writing reports for various state activities.

Before joining HSAG, Dr. Chotkevys was responsible for operational oversight of external quality review contracts in the three states. Dr. Chotkevys worked with MCOs and providers to assess and monitor care and provided direction for medical record abstraction for quality studies, on-site reviews, and technical assistance to the state bureaus. Her responsibilities included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts, state requirements, and federal requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, credentialing, and working with the waiver clients to assist with customer service issues; designing and developing quality studies to monitor care; and working with scientists, statisticians, and health analysts to interpret data.

Dr. Chotkevys holds a Master of Business Administration Degree from Baldwin-Wallace College and a Doctor of Health Administration Degree from the University of Phoenix. She currently teaches health administration courses at local and on-line universities as an adjunct professor (part-time).

Wendy Talbot, MPH, CHCA, is an Associate Director of Audits at HSAG and is responsible for the oversight and management of HSAG's NCQA HEDIS® Compliance Audit program as well as the Validation of Performance Measures activities for its EQRO contracts. Prior to her appointment to her current position, Ms. Talbot served as the Arkansas project manager, overseeing the day-to-day contract activities for HSAG's Arkansas data mining and program evaluation contract. She was also a project manager within the Audit Department, where she was responsible for support of the HEDIS audit program and all performance measure validation activities, including communicating with health plans, preparing agendas and scheduling and conducting site visits, reviewing the systems capabilities tools completed by the health plans, reviewing programming logic and output files, and compiling audit results into a final audit reports. Ms. Talbot is an NCQA-Certified HEDIS Compliance Auditor, and she is skilled in

primary source verification of eligible population and numerator files, ensuring algorithmic compliance, and assessing bias using NCQA and CMS techniques and protocols.

Her previous roles at HSAG included project coordinator for performance improvement projects, performing validation of physical and behavioral health PIPs, and participating on external quality review and compliance audits of Michigan mental health plans. She also served as a health care analyst with HSAG's Federal Division, providing analytic support for the CMS 7th Scope of Work quality improvement organization (QIO) contract and analyzing and reporting on ambulatory care and inpatient data, including mammography, diabetes, and immunizations.

Ms. Talbot has more than seven years of experience in epidemiology, data analysis and management, and health care/disease program management with state Medicare/Medicaid programs. She holds a Bachelor of Science degree in Health Sciences from the University of Nevada at Reno and a Master of Public Health degree from the University of Arizona, with emphasis in epidemiology.

Christi Melendez, RN, **CPHQ,** is the Associate Director of Quality Improvement Projects at HSAG and is responsible for leading the plan-specific, small-group, and collaborative PIP validation activities and tasks performed by the HSAG PIP Validation Team. Ms. Melendez has been with the company since 2001. She has more than 20 years of nursing experience in the clinical and home health settings, including case management and medical record reviews. In her current role, she works closely with the PIPs manager to validate health plan performance improvement projects by assessing the implications on the validity and reliability of the PIP findings. Ms. Melendez is responsible for providing technical assistance and training to states, as needed. In addition, she is also an RN abstractor/coordinator, performing review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She has assisted in the training of other RN abstractors and has provided on-site medical reviews for HEDIS auditing.

Ms. Melendez's prior experience includes 14 years of case management of long-term, chronically ill children, maternity and pediatric patients, and home health infusion patients. She was responsible for preparing quality assurance and treatment plans as well as performing medical record/documentation audits. She was actively involved in performance improvement activities.

Ms. Melendez is a Registered Nurse with an Associate of Science Degree in Nursing from Cypress College in California. She recently became a Certified Professional in Healthcare Quality (CPHQ).

Diane Christensen, LPC, is a Director, EQRO Services with HSAG's State & Corporate Services Division. She is responsible for leading or serving as a resource for the division's projects and acts as a contract liaison and directs EQRO activities for individual states. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Ms. Christensen is an Arizona Licensed Professional Counselor with over 20 years of senior leadership experience in health care management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral health care settings.

In her previous role with AHCCCS, the Arizona Medicaid agency, she monitored and evaluated the quality of behavioral health services provided to Medicaid enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through contracted acute care and Arizona Long Term Care Services (ALTCS) contractors. She performed analysis and interpretation of federal and state regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Prior to that, she was the assistant director of policy oversight for a national behavioral health organization, with responsibility for interpreting, implementing, and complying with private health care insurance regulations across the 50 states. Ms. Christensen designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance, and she prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance.

Ms. Christensen holds a Masters of Counseling Degree from Arizona State University and a Bachelor of Science Degree in Secondary Education (English/Speech) from West Virginia University.

Tom Miller, MA, is Executive Director, Research and Analysis Team, and has been with HSAG since December 2003. In his current role, Mr. Miller is responsible for oversight of all State & Corporate Services Division analysis activities and staff, including coordinating all HSAG analytic activities, implementing quality control processes, and training and oversight of State & Corporate analysts. Mr. Miller has more than 10 years of experience performing statistical analysis in the health care setting, including Medicaid managed care, pharmacy benefit management, disease management, and claims processing. He has extensive experience managing retrospective and survey research studies and encounter data validation studies involving the coordination of internal and external customers. Mr. Miller has worked with NCQA/QISMIC Accreditation Standards and HEDIS performance measures (including work with CAHPS). He has performed highly technical data manipulation/analysis to render meaningful interpretations, and to translate quantitative and qualitative research into operational goals and standards and improvement activities.

As head of the Analysis Team, Mr. Miller provides research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytical staff. He has been involved in designing and executing numerous focused studies, including evaluations of perinatal care, asthma management, lead screening, adolescent health care, and childhood immunizations in Ohio; perinatal care, asthma management, preventive services for persons with disabilities in Colorado; and EPSDT services for school-aged children in Michigan. Mr. Miller has also been involved in conducting encounter data validation activities for physical health programs in Hawaii, Ohio, and Tennessee; and for prepaid mental health plans in Utah. Additionally, Mr. Miller has worked on a variety of other projects, including case management reviews in Arizona and Ohio, HEDIS reporting in Florida, Ohio, and Michigan, evaluation of provider networks and

benefit delivery in Tennessee and Nevada, Medicaid provider surveys in Colorado, and coordination of compliance audit sampling activities. He acts as a SAS and GeoAccess expert resource for the Research and Analysis Team.

Mr. Miller holds a Bachelor of Science Degree in Sociology and Psychology from Northern Arizona University and a Master of Arts Degree in Sociology from the University of Cincinnati. He is a member of the AcademyHealth organization.

Proposed Approach and Methodology

HSAG's approach to developing a comparative MCO report for BMS will include establishing, in collaboration with BMS, the specific and preferred methodology for making the MCO comparisons and determining the benchmarks or targets to be used for these comparisons. HSAG recognizes that each state has quality strategy goals that are unique to its Medicaid population and demographics, prevalent health care issues within the geographic area served, and the state's priorities for quality improvement. As such, HSAG will work with BMS to identify the most important aspects for performance improvement comparisons and will make recommendations for presenting such information to the State and its stakeholders. Specific steps to achieving a useful comparative report of MCO performance include the following:

Develop The Approach

Through planned phone calls or face-to-face meetings with BMS, HSAG will seek to gain a clear understanding of BMS' expectations about report timelines, goals for the report, time frames for the data that will be used for comparative analysis, intended audience for the report, and the preferred methodological approach for making the comparisons (e.g., to national benchmarks or statewide averages). HSAG subject matter experts for each of the mandatory EQR activities will develop and describe the proposed methodology that will be used to aggregate, analyze, and compare MCO EQR activity data and the basis that will be used to compare the results.

HSAG will draft a timeline and report outline that responds to BMS' needs. Once review and feedback are provided by BMS, HSAG will adjust the outline and timeline. The approved outline will be followed to create a report template for the writers' use in developing the comparative MCO report content. The project director will be responsible for convening a team meeting to communicate the timeline, goals and expectations, presentation and writing style decisions, intended audience, and report outline to the team responsible for the comparative MCO report.

Compile and Analyze the Data

Content area experts will use MCO data obtained through conducting the EQR activities and other quality information made available by BMS. In order to ensure that the data are complete and accurate, HSAG's Research and Analysis Team will determine how the data were collected, by whom, and whether the data were accurately defined and described. HSAG understands that the data must be valid and must capture the key and meaningful aspects of care in order for valid comparisons to be made. HSAG's experienced team of analysts follow strict and current industry standards in their statistical practices for analyzing data and making comparisons. The comparative MCO report will contain information derived from use of appropriate and rigorous

statistical and methodological guidelines and will arrive at valid, reliable, and accurate conclusions and comparisons with respect to the MCOs' performance in providing quality, timely, and accessible services to Medicaid recipients.

Through its extensive experience in conducting the EQR activities, HSAG has established, maintains, and continually updates a large database of Medicaid health plan data. Having ready access to these data, HSAG is able to provide meaningful and credible conclusions about MCO performance results using comparisons to available local, regional, and national benchmarks.

DRAFT THE COMPARATIVE MCO REPORT

The narrative discussion of the results of the MCO comparisons will include conclusions drawn from the data and identify the MCOs' strengths and weaknesses in providing quality, timely, and accessible care and services. Subject matter experts will provide the content for this report based on their hands-on experience conducting the EQR activities for the West Virginia MCOs. The HSAG Reports Department will support the development of the report with technical writers and editors to ensure clarity and consistency in the format and presentation of the report.

HSAG's analysts and its editorial staff members collaborate and are creative in designing innovative, meaningful, and state-of-the-industry ways to present the comparative data and the quality assessments and conclusions derived from performing the comparisons. HSAG presents data in a way that is immediately visually informative and meaningful, including use of color graphs, charts, and flow diagrams and other design elements to present an easily accessible picture of performance. Working with its professional editors, HSAG's analysts use state-of-the-industry tools (e.g., Statistical Analysis Software [SAS]) to generate graphs that enhance the visual presentation of quantitative information.

To ensure that the annual comparative MCO report meets the highest professional standards for accuracy of content, writing style, and readability, all staff members involved in preparing the report (i.e., analysts, content experts, report production staff, and managers/directors) will be involved in the quality assurance and control processes. The report will undergo a review by technical writers, editors, and other readers to provide a second level of review for accuracy, completeness, and readability, and to provide objective perspectives and feedback on the report prior to sending the draft to BMS for its review. HSAG welcomes and values candid feedback from its state clients on its draft reports.

FINALIZE THE COMPARATIVE MCO REPORT

After BMS' review and comment on the draft comparative MCO report, HSAG will discuss and clarify any areas of feedback with BMS and then revise the report as indicated. Once approval is obtained, HSAG will prepare the final report and submit it to BMS in the formats (electronic, CD, printed) and number of copies requested.

Work Plan

HSAG has developed the following work plan and project activities timeline.

Initial	Resource Category	Name
OPD	Overall Project Director	Bonnie Marsh, BSN, MA
WVPD	West Virginia Project Director	Debra Chotkevys, DHA, MBA
PMV	Assoc. Director, Audits	Wendy Talbot, MPH, CHCA
PIP	Assoc. Director, PIPs	Christi Melendez, RN, CPHQ
CR	Director, Compliance Reviewer	Diane Christensen, MC, LPC
RA	Dir., Research and Analysis Team	Tom Miller, MA
DRD	Director, Reports Department	Cheryn Wall, EdD

Task and Sub-Task/Description	Responsibility	Start Date	End Date
Develop Approach			
Discuss with BMS the goals, intended audience, and timeline for the comparative MCO report. Determine desired methodology for MCO comparisons (e.g., statewide average, national benchmarks, state quality strategy goals).	OPD, WVPD	7/3/12	8/3/12
Develop proposed data presentation style(s) and obtain BMS feedback and approval.	WVPD, RA, DRD	8/3/12	8/31/12
Develop draft table of contents and proposed outline for the comparative MCO report and discuss with BMS. Obtain feedback, make adjustments, and finalize when approved.	PD, DRD	9/4/12	10/1/12
Prepare report template according to approved outline, and distribute report sections to EQR team members. Discuss and clarify approach, timeline, BMS goals, and intended audience with assigned team.	OPD, WVPD, PIP, PMV, CR, RA, DRD	10/1/12	11/2/12
Compile and Analyze Data			
Compile, analyze, and summarize EQR activity data across MCOs, and display in approved data presentation style(s).	RA	12/3/12	1/2/13
Validate EQR activity results data against source documents.	RA	1/2/13	1/7/13
Provide current comparative data fields (e.g., national benchmarks) based on approved methodology and approach, and derive preliminary comparative conclusions for each MCO and each EQR activity.	RA, WVPD, PIP, PMV, CR	1/7/13	1/14/13
Draft Comparative MCO Report			
Draft narrative discussion of comparisons and conclusions for each MCO for each EQR activity.	RA, WVPD, PIP, PMV, CR	1/14/13	2/11/13
Perform peer and technical review of draft report.	ED, WVPD, DRD	2/11/13	2/28/13
Provide draft report to BMS for review and comment. Discuss and respond to any questions or feedback, and incorporate changes into report, as appropriate.	ED, WVPD	3/1/13	3/22/13
Finalize Comparative MCO Report			
Perform final peer and technical review of comparative MCO report. Produce electronic and printed/bound copies, as agreed.	ED. WVPD, DRD	3/22/13	3/28/13
Deliver final annual comparative MCO report to BMS.	WVPD	3/29/13	3/29/13

2.4.11 Yearly Operations Plan

2.4.11	Vendor should propose a yearly Operations Plan that addresses compliance with all of the following program requirements: Validating and reviewing PIPs, performance measures and annual compliance reviews. The Operations Plan should include a timeline of events.

HSAG acknowledges that according to Addendum No. 1 of the External Quality Review Organization RFP, Section 2.4.11 has been deleted. Therefore, no response has been provided.

2.4.12 HSAG's Expertise with Federal Statutes, Regulations, and Guidance

2.4.12 Vendor should demonstrate their expertise in Federal statutes, regulations, and guidance related to quality assurance and performance measurement including the Patient Protection and Affordable Care Act (PPACA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Experience With Similar Projects

DEMONSTRATED EXPERTISE IN FEDERAL STATUTES, REGULATIONS, AND GUIDANCE

HSAG has an acute understanding of the Balanced Budget Act of 1997 (BBA) and its resulting EQR regulations at 42 CFR §438 and, in particular, 42 CFR §438.364 (External Quality Review Results). As the provider of EQR services in 14 states, HSAG has applied its acute understanding to interpreting and administering current federal requirements for Medicaid external quality review, including the EQR regulations and the CMS Protocols. In addition, since the release of the protocols, HSAG has worked closely with both the CMS Regional and Central offices to clarify any issues regarding regulation or protocol interpretation. Because HSAG conducts business in almost all of the CMS regions, it is of vital importance that HSAG continually confer with CMS to ensure compliance with the regulations and protocols.

Since their release on May 1, 2002, (protocols for validating performance measures; validating performance improvement projects; and conducting focused studies) and February 1, 2003, (protocols for monitoring Medicaid managed care organizations and prepaid inpatient health plans), HSAG has incorporated the use of the CMS Protocols into all 14 of HSAG's EQR contracts.

In order to ensure compliance with policies and processes, HSAG stays fully informed of the applicable Medicaid and Children's Health Insurance Program Reauthorization (CHIPRA) laws, regulations, policies, and trends. HSAG has experience working with numerous states to report CHIPRA performance measure rates to CMS. For example, HSAG developed a methodology for combining data collected by the State of Georgia's Department of Community Health (DCH) and its contracted care management organizations that allowed the State to report CHIPRA rates to CMS without having to initiate additional, costly medical record abstraction. DCH was most recently highlighted in the 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP report released by the Department of Health and Human Services for reporting the highest number of CHIPRA measure rates. The methodology created by HSAG will allow the State to report additional measure rates in subsequent years. In Arkansas, HSAG has conducted a comparative review of EPSDT requirements across multiple states to identify similarities and differences with regard to various EPSDT Medicaid programs in order to determine potential causes for differences in performance.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

In addition, the HSAG staff monitors state informational sources—including related federal and

state legislation, rules, and regulations—and industry standards sources such as the National Committee for Quality Assurance (NCQA) and The Joint Commission (TJC). In turn, HSAG staff members update and inform HSAG's EQR contracted states of national and state issues and standards for managed care populations, §1115 and 1915 Waivers, changes in requirements under the PPACA and BBA, changes to HIPAA, etc.

HSAG has an extensive amount of experience in evaluating CMS programs created from or modified due to the Affordable Care Act (ACA). For instance, HSAG has assisted CMS in the maintenance and accuracy of the Hospital Compare Web site as part of CMS's Hospital Quality Initiatives (HQI) Measure Implementation Support Contract. HSAG's responsibilities include periodically reviewing the Web site for any quality issues or concerns and performing User Acceptance Testing (UAT) quarterly. Through this process, HSAG has performed a full validation and independent review of Hospital Compare each quarter prior to the release of quality measure data since April 2011. In the near future, many of the measures presented on Hospital Compare will be used to establish a value-based purchasing program for Hospitals which was established by the ACA. In addition, HSAG is responsible for documenting and enhancing the Hospital Compare Quality Assurance (QA) Plan, which involves evaluating more than 10 CMS contractors' QA plans and providing recommendations for improvement.

In addition, as part of CMS's Physician Public Reporting Programs (PPRP) Contract, HSAG is currently in the process of conducting a thorough literature review of physician and other practitioner public reporting programs. This activity is part of a larger scope to review and align various physician public reporting programs in existence. Through this work, HSAG reviews numerous ACA-mandated programs, as well as programs affected directly by the ACA, such as Medicare Shared Savings Program, the Physician Compare Web site, Physician Quality Reporting System (PQRS) Program, and the Electronic Health Record (EHR) Incentive Program. The work from this literature review will serve as the foundation for a 2015 report to Congress, which will address the efforts taken to date to collect and report quality data and put forth recommendations for future legislative requirements.

Finally, HSAG holds the contract for CMS's Project Evaluation Activity in Support of Partnership for Patients (PfP). The PfP was awarded $500 million in funding to help hospitals, health care provider organizations, and others improve care and stop millions of preventable injuries and complications related to health care acquired conditions and unnecessary readmissions. Specifically, the initiative seeks to decrease preventable inpatient harm by 40 percent and readmissions by 20 percent by the end of 2013. As part of this contract, HSAG serves as the PfP Project Evaluation Contractor (PEC) and is responsible for conducting a formative evaluation of the PfP initiative, performing an impact analysis of the PfP initiative on health care outcomes and spending, and auditing hospitals that claim to achieve a substantial reduction in harms and readmissions.

As part of its Measures Manager contract with CMS, HSAG is tasked with assessing the validity of new performance measures in support of the Patient Protection and Affordable Care Act (PPACA) requirements for quality measurement and public reporting settings such as long term care hospitals (LTCHs), ambulatory surgery centers (ASCs), hospices, psychiatric facilities, and cancer hospitals.

2.4.13 HSAG's Knowledge of "Best Practices"

2.4.13 Vendor should demonstrate their knowledge of "best practices" in performance improvement and their ability to work with MCOs to improve results.

As an EQRO in 14 states and a QIO in three states, HSAG stays well-connected to the health care quality improvement professional network, both formally and informally. HSAG has, and keeps current, its knowledge of quality measurement and improvement techniques and best and emerging practices in health care through these roles as EQRO and QIO.

At the end of HSAG's first three-year contract as the Medicare QIO for California, the Centers for Medicare & Medicaid Services (CMS) awarded HSAG of California its "QIO Quality Champion Award" at the 2010 CMS QualityNet conference, demonstrating HSAG's commitment to and excellence in quality improvement. Moreover, HSAG is the only QIO in the nation that has been awarded several special projects from CMS, providing it with invaluable experience and knowledge and demonstrating HSAG's ability to successfully handle large-scale, complex, quality improvement work. HSAG's QIO executives participate in and provide leadership to the American Health Quality Association (AHQA). Sharing best practices and knowledge transfer across Medicare and Medicaid allows HSAG to be on the cutting edge of quality improvement.

Currently, HSAG is the largest EQRO in the nation, providing EQR services and evaluating the quality, access, and timeliness of care that Medicaid recipients receive in its 14 contracted states for more than 38 million of the nation's Medicaid population. In several of these EQRO contracts, HSAG has taken the lead role in developing and conducting initiatives to improve quality of health care for Medicaid members. HSAG has demonstrated experience providing consultation related to quality improvement, assurance, and program evaluation to managed care plans. These years of accumulated experience have allowed HSAG to collect a wealth of knowledge and expertise in developing, monitoring, and assisting in all aspects of actionable interventions that produce positive change within managed care organizations.

HSAG has held several of its state contracts since the inception of the EQRO requirement and federal managed care regulations or for the entire period that a state has provided Medicaid services through a managed care waiver. As such, HSAG is able demonstrate its ability to positively impact quality, compliance, and outcomes over time and in numerous managed care organizations across the country. In addition, states where new managed care programs have been initiated during HSAG's tenure as the EQRO have benefitted from HSAG's technical assistance and insights into managed care quality practices. HSAG has also partnered with many of these states to perform MCO readiness reviews.

Specific examples providing evidence of HSAG's ability to work with MCOs to effect improved results follow.

- **California's Readmission Measurement—**HSAG is currently providing technical

assistance to the State of California's Medi-Cal Managed Care Program for the reduction of hospital readmissions. The State, in collaboration with its 20 Medi-Cal managed care plans, selected the topic of hospital readmissions as its statewide collaborative performance improvement project. HSAG has worked with the State and its health plans to develop a readmissions performance measure that could be used to measure hospital readmission rates consistently across the 20 plans, ensuring the measure is appropriate for the Medicaid population.

- **Nevada's Quality Strategy Tracking Table—**HSAG developed the Quality Strategy Goals and Objectives Tracking Table for the State of Nevada to continually track its progress in achieving the goals and objectives outlined in the State's Quality Strategy. The table lists each of the four goals and the corresponding objectives the State identified as priorities for improvement, and each objective is measured by a defined HEDIS indicator (e.g., "To improve the health and wellness of Nevada children, childhood immunization status—combos 2 and 3 must improve by 10 percent."). In 2010-2011, there were 19 indicators that measured achievement of the State's Quality Strategy goals and objectives. Using a hybrid Quality Improvement System for Managed Care (QISMC) methodology for establishing performance targets, the State set the benchmark that each of the HEDIS indicators should improve by 10 percent. HSAG participates in quarterly meetings with Nevada MCOs and State staff members. This forum enables HSAG to facilitate discussion about the indicators used to measure achievement of the goals. HSAG and the State also identify "homework" for the MCOs wherein they must present their approaches to improve performance for each of the goals. These discussions assist the MCOs with identifying improvement interventions that can be rapidly applied to improve their indicator rates. HSAG updates the Quality Strategy Goals and Objectives Tracking Table annually to display the MCOs' achievement of the goals. Since HSAG developed this tracking table, and with the State's heightened focus on MCOs' participation in ongoing quality strategy discussions facilitated by HSAG, the Nevada MCOs have demonstrated improvement in access, timeliness, and quality of services provided by Medicaid recipients.
- **Nevada's Reducing Avoidable Emergency Room (ER) Visits Work Group**—During FY 2010–2011, HSAG worked with the Nevada Division of Health Care Financing and Policy (DHCFP) and the MCOs to examine avoidable emergency room use and the frequency with which some members accessed ERs. HSAG facilitated monthly work group discussions aimed at analyzing data and identifying the reasons Medicaid recipients frequented the ER inappropriately. At the direction of HSAG, MCOs examined ER usage patterns and discovered that there were a number of members who inappropriately used the ER for primary care instead of establishing a relationship and a "medical home" with a primary care provider (PCP). An analysis of diagnoses showed that many of the ER visits were nonemergent or emergent but treatable by a PCP. The Reducing Avoidable Emergency Room (ER) Visits Work Group continued to meet regularly to develop interventions to reduce inappropriate and/or avoidable ER utilization. To identify the individuals who would likely benefit from targeted care manager interventions (or re-education on establishing a relationship with a PCP), HSAG and DHCFP asked the MCOs to identify the number of individuals who visited the ER at least three or more times in a three-month period during the last calendar quarter of 2010. The MCOs were required to stratify these data by gender, age, race/ethnicity, time of day, county, and diagnostic category to determine which populations

could benefit from more targeted interventions. The subject of inappropriate ER use continues to be a priority focus area for the State of Nevada Medicaid agency and the MCOs have developed a collaborative PIP to continually assess and apply intervention strategies to educate members and navigate nonemergent care back to PCPs, urgent care facilities, or other appropriate alternatives.

Since an organization's culture of continuous quality improvement emanates from its leadership, the HSAG staff has received training on such practices as the "LEAN" quality system of process analysis and improvement and other rapid-cycle improvement practices. Through its experienced and accomplished staff, HSAG will supply consultation, expertise, suggestions, and advice to assist with BMS' decision-making and strategic quality improvement planning for its Medicaid program and contractors. HSAG is attentive in providing excellent service and to working closely with the State and MCOs, assuring that there is always a supportive and coordinated approach in carrying out all technical assistance that HSAG will provide to the MCOs.

2.4.14 Vendor References

2.4.14 Vendor should provide three (3) references (excluding West Virginia) from similar projects of work performed within the past five (5) years along with a detailed description of the work performed for each reference. Each referenced project should include one (1) or more key staff member from the list of staff proposed for this project. References should include:

- Names of the staff members who worked on the project;
- Time period of the project;
- Scheduled and actual completion date;
- Organization name, address, and current telephone number; and
- Contact name, phone number, and e-mail address of project administrator familiar with the Vendor's performance.

In the tables below, HSAG has provided three references for similar projects performed within the past five years. The references include a detailed description of the work performed, key HSAG staff members who worked on the project, dates of performance, organizations names, and contact information for project administrators.

HSAG has also provided, at the end of this section, full descriptions of its EQRO and Federal contracting experience.

Colorado	
Name of Contract:	**State of Colorado** **Department of Health Care Policy and Financing (DHCPF)**
Primary Contact Person:	Katie Brookler Strategic Projects Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 Phone: 303.866.6173 E-mail: Katie.brookler@state.co.us
Dates of Performance:	7/1/08–6/30/13 The current contract is combined for Medicaid physical health, behavioral health and the state's Child Health Insurance Program. Previous contract period: 5/01/01–6/30/08. Prior to being combined in the current contract, these projects were awarded to HSAG in three (3) separate contracts.
HSAG Staff Members:	Diane Somerville, MSW Gretchen Thompson, MBA, CPHQ Christi Melendez, RN, CPHQ Wendy Talbot, MPH, CHCA Barbara McConnell, MBA, OTR Tom Miller, MA David Mabb, MS, CHCA

Colorado

Description of Services Performed and Deliverables:

HSAG is the external quality review organization (EQRO) for the Colorado Medicaid Managed Care Program and Children's Health Insurance Program, called Child Health Plan *Plus*, or CHP+. Duties include an independent external review of the quality of medical and behavioral health care and services provided to Colorado Medicaid and CHP+ clients, including the managed care organizations (MCOs), behavioral health organizations, (BHOs), Primary Care Physician Program (PCPP), and Unassigned Fee-For-Service (FFS) program.

Under this contract, HSAG:

Validates Performance Improvement Projects (PIPs), up to two PIPs for each MCO and BHO. HSAG assesses the plans' methodology for conducting the PIPs and evaluates overall validity and reliability of PIP results. HSAG reports the findings of the validation activity in individual MCO/BHO reports and also incorporates the information in the technical report.

Conducts Annual On-Site Compliance monitoring reviews for all of Colorado's Medicaid and CHP+ MCOs and BHOs to determine compliance with the access to care, structure and operation standards, enrollee rights and protections, and quality assessment and performance improvement regulations identified in the State's contract and the BBA managed care regulations. HSAG prepares individual MCO/BHO reports of findings, strengths, and opportunities for improvement. HSAG also incorporates data from the reviews into the annual statewide EQR Technical Report.

Conducts on-site Validation of Performance Measure audit for each BHO, the PCPP, and the Unassigned FFS program in accordance with CMS protocols. HSAG produces individual reports for each BHO, the PCPP, and the Unassigned FFS and incorporates the results of the activity into the annual EQR Technical Report.

Performs CAHPS Surveys for adults and children enrolled in the Medicaid PCPP and Unassigned FFS populations and the CHP+ program. HSAG annually conducts the surveys in both English and Spanish for the adult and child populations. HSAG administers the surveys in accordance with NCQA protocols. HSAG produces plan-specific reports annually for each population and produces an aggregate CAHPS report.

Prepares a detailed EQR Technical Report combining physical health and behavioral health that describes the manner in which the data from all EQR activities (compliance audits, PIP and PMV validation, HEDIS data), were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCOs/BHOs.

The technical report also includes an assessment of each MCO/BHO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Hawaii	
Name of Agency:	**State of Hawaii** **Department of Human Services** **Med-QUEST Division**
Primary Contact Person:	Chris Butt Contract Monitoring & Compliance Section Hawaii Department of Human Services, Med-QUEST Division 601 Kamokila Boulevard, Room 506B Kahuhihewa Kapolei State Building Kapolei, HI 96707-2021 Telephone: 808.692.8165 E-mail: cbutt@medicaid.dhs.state.hi.us
Duration of Project:	7/01/01–12/31/12
HSAG Staff Members:	Bonnie Marsh, RN, BSN, MA Gretchen Thompson, MBA, CPHQ Christi Melendez, RN, CPHQ Tom Miller, MA

Description of Current Services Performed and Deliverables:

HSAG provides external quality review (EQR) services for the QUEST and QExA programs for the Department of Human Services, Med-QUEST Division (MQD), as well as Peer Review Organization (PRO) services for the Fee-For-Service (FFS) and managed care populations. Hawaii EQR services include:

Monitors Compliance of MCOs through on-site reviews to determine their compliance with Medicaid managed care regulations and State requirements in the following areas:

- Enrollee rights and protections.
- Access standards.
- Structure and operational standards.
- Quality Measurement and Improvement
- Grievance system.

Reviews MCOs' Corrective Action Plans (CAPs) for any standards not fully compliant. HSAG provides the MCOs with a CAP template that identifies the areas needing to be addressed. Following receipt and review of the CAP, HSAG provides feedback to the Med-QUEST Division and the MCOs regarding the likelihood of the CAP resulting in compliance.

Provides Technical Assistance to the MQD and MCOs to address questions and specific expectations for their participation in the external quality review activities. In addition, HSAG provides assistance to the MQD on a variety of special projects, such as preparation of a consumer guide, review and feedback on survey instruments under development, review and feedback on the State's quality strategy, etc.

Validates Performance Improvement Projects (PIPs) for each of the MCOs. Using the current CMS protocols, HSAG evaluates the soundness and results of two of the PIPs implemented by the MCOs, and produces a written report of findings and recommendations.

Hawaii

Conducts a Provider Satisfaction Survey of the primary care physicians (PCPs) and high-volume specialty physicians for each MCO every other year. HSAG is responsible for survey methods and design, survey production, administration, and data analysis. HSAG prepares a written report of survey results.

Prepares a detailed EQR Technical Report that describes the manner in which the data from all mandatory and optional activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by Med-QUEST-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each plan; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Vermont

Name of Agency:	**Vermont Agency of Human Services (AHS)**
Primary Contact Person:	Shawn Skaflestad, PhD Quality Improvement Manager Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203 Telephone: 802.241.1160 E-mail: Shawn.Skaflestad@ahs.state.vt.us
Duration of Project:	11/15/07–11/14/11
HSAG Staff Members:	Diane Christensen, LPC Bonni Marsh, RN, BSN, MA Gretchen Thompson, MBA, CPHQ Christi Melendez, RN, CPHQ Wendy Talbot, MPH, CHCA

Description of Services Performed and Deliverables:

As the contracted external quality review organization (EQRO) for the Vermont Agency of Human Services (AHS), HSAG's external quality review (EQR) activities focus on the MCO programs operated by the statewide MCO, the Department of Vermont Health Access (DVHA), formerly the Office of Vermont Health Access (OVHA), through its inter-governmental agreements with AHS Departments/Divisions and a network of community-based providers. The scope of work includes the three mandatory activities:

- Validation of AHS-required performance improvement projects.
- Validation of AHS-required performance measures.
- Review of MCO compliance with federal and AHS-specified standards for quality program operations.

Vermont

In addition, HSAG prepares an annual EQR technical report and provides technical assistance and guidance to the AHS and/or the DVHA quality improvement and operations staff to support their goals and activities in providing timely, accessible, and quality services to beneficiaries.

Validation of Performance Improvement Projects (PIPs) involves HSAG annually validating the DVHA's PIP(s). As part of its validation activities, HSAG evaluates the measurement of specific outcome indicators. HSAG prepares and submits to AHS and DVHA an annual PIP validation report of its validation activities and DVHA's PIP performance results.

Validation of Performance Measures designated by the AHS. HSAG's validation of DVHA's performance measures includes:

- Evaluating the accuracy of performance measures reported by, or on behalf of, the MCO.
- Determining the extent to which the performance measures calculated by the DVHA (or entity acting on behalf of the MCO) followed specifications established by the State for the calculation of performance measures.

HSAG validates data reported by the DVHA and assists AHS by preparing measure specifications and the data submission tool used by the MCO to meet each year's data collection requirements. HSAG prepares a Validation of Performance Measures Report upon completion of this annual activity.

Review of Compliance with Standards involves HSAG's evaluation of the DVHA's performance with respect to its compliance with the federal Medicaid managed care and AHS-specified IGA (contract) requirements and standards. HSAG conducts both a desk review of the DVHA's documentation and an on-site review of additional documents and interviews with key DVHA management and program staff members. HSAG prepares a narrative summary report of reviewer findings that includes a presentation and analysis of the findings and performance data/scores, a summary of the DVHA's strengths and opportunities for improvement, and recommendations to improve its performance related to the quality and timeliness of, and the access to, care and services provided by the MCO.

Preparation of an EQR Technical Report, includes describing the manner in which, in accordance with 42 CFR 438.358, HSAG aggregated and analyzed the data from all EQR activities and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO operated by the DVHA. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of the MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries; recommendations for improving performance related to these same aspects of health care services; and an assessment of the degree to which the DVHA has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

HSAG'S EQRO AND QIO CONTRACT EXPERIENCE

HSAG performs its EQRO functions in accordance with federal and state laws, regulations, and policies regarding Medicaid—including standards and procedures pertaining to the terms and conditions of the applicable waiver programs.

HSAG works collaboratively with the state Medicaid agencies for which it performs EQR services to improve the quality of care and services provided to the Medicaid beneficiaries. This effort involves interfacing with policymakers and advocacy groups at the state level. HSAG also collaborates with each state's staff to develop the state quality improvement plans and to design initiatives that will result in measurable outcomes.

HSAG has more than 20 years of experience performing external quality review activities. HSAG began performing external quality review activities for the Arizona Health Care Cost Containment System (AHCCCS) in 1990. HSAG's experience performing EQR activities for each state, including the number of years of experience, costs, and start and completion dates is as follows:

Arizona	
Name of Agency:	**Arizona Health Care Cost Containment System (AHCCCS)**
Primary Contact Person:	Kim Elliott, PhD, CPHQ Arizona Health Care Cost Containment System 701 East Jefferson, MD 6700 Phoenix, AZ 85034 Telephone: 602.417.4782 E-mail: kim.elliott@azahcccs.gov
Duration of Project:	9/30/90–9/29/12
Cost of Project:	[redacted]
Description of Services Performed and Deliverables:	

Since 1990, HSAG has performed external quality review (EQR) services for AHCCCS, including the following current and past activities:

Prepares a detailed EQR Technical Report, as required in the current contract scope of work. The technical report describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by AHCCCS-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Arizona

Conducted an Annual Focused Clinical Quality of Care Study on Immunization Status of 2-year-old children enrolled in the AHCCCS program. In a concerted effort to improve the immunization status of children and achieve the immunization goals set by *Healthy People 2010*, HSAG also provided the 13 AHCCCS health plans with a tool for quality improvement in this area. The primary analysis provided results on the percentage of 2-year-old members who were age-appropriately immunized for each of the six HEDIS quality indicators. HSAG provided temporal results, along with additional analysis to identify "missed opportunities" and the degree of partially immunized children, both by health plan and county. HSAG submitted a final report to AHCCCS, the Governor, and the Arizona Legislature.

Arkansas

Name of Agency:	**State of Arkansas** **Department of Human Services, Division of Medical Services**
Primary Contact Person:	Sheena Olson, JD, MPA Assistant Division Director for Medical Services Donaghey Plaza South Suite 1100 Little Rock, Arkansas 72203-1437 Telephone: 501.683.5287 E-mail: sheena.olson@arkansas.gov
Duration of Project:	7/1/10-6/30/12
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

The Arkansas Division of Medical Services (DMS) has contracted with HSAG to develop and manage the Medicaid data mining and program evaluation activities. This contract includes four activities: data mining and utilization analysis, HEDIS aggregation and calculation, program evaluations, and PCP and hospital ER utilization profiling.

In collaboration with DMS, HSAG conducts up to eight data mining and utilization analysis projects targeting key health care topics critical to the management of the Medicaid program and consumers. Each study is based on sound methodological designs that allow for a thorough evaluation of performance key drivers of quality and program performance. Where appropriate, HSAG incorporates national literature to provide an appropriate policy context for the findings as well as to outline potential areas for quality improvement. Projects have included a comprehensive evaluation of cesarean delivery rates, validation of Federal EPSDT reporting, implementation of CHIPRA measure report, hospital readmissions, and emergency department utilization.

HSAG is also involved in the calculation and aggregation of Arkansas' HEDIS measures. On an annual basis, HSAG collects data from the Medicaid program using administrative and hybrid methods in order to generate a comprehensive set of measures for evaluating overall performance of Arkansas' Medicaid program. Based on its analysis, HSAG is responsible for generating both a detailed notebook of results containing detailed tables and breakouts of the

Arkansas

results by key demographic variables, as well as a consumer-focused booklet. The booklet is designed to provide consumers with high level summary of the results and what they mean for the State of Arkansas.

Additionally, a series of program evaluations will also be conducted throughout the contract year. Unlike the data mining and utilization analysis activities, the program evaluations represent a more in-depth analysis of key Medicaid programs (e.g., EPSDT and various waiver programs.) Developed and executed in coordination with the State of Arkansas, these analyses generate reports that highlight key trends and outcomes. Currently HSAG has conducted a comparative review of EPSDT requirements across multiple states as well as an evaluation of beneficiaries' satisfaction with a newly implemented dental program.

Finally, HSAG is responsible for generating primary care physician and emergency room usage profiles on a quarterly basis. Highlighting both specific targeted areas and general performance, the profiles are designed to show individual providers and facilities how they are performing against state and national benchmarks. These profiles serve as a key reference for direct communication and improvement activities with Medicaid providers.

Specific projects HSAG is currently conducting include:

Program Evaluations

Comparative Review of EPSDT Requirements – HSAG compared Arkansas' EPSDT program requirements to other states with similar programs. The comparison allowed HSAG to identify similarities and differences in the contents of the EPSDT manuals across the selected states. The findings provided insight into how Arkansas' EPSDT billing policies and procedures compared to these other states and potentially affected reported performance.

ARKids B/TEFRA Programs CMS Evaluation Design – HSAG prepared the evaluation designs for the ARKids B and TEFRA program demonstration projects as part of renewal requirements.

Annual Dental CAHPS Survey – HSAG conducted the dental CAHPS survey to evaluate beneficiary satisfaction with the Arkansas dental program. Arkansas-specific program questions were integrated into the survey to capture specific information on Medicaid enrollees' experiences.

Data Mining

- Cesarean Delivery Rates – This project uses the state's Medicaid data to evaluate deliveries to determine the cesarean delivery rate for all births in state fiscal year 2010. The cesarean delivery rates were analyzed by age, race, county, region, hospital, and provider.
- Validation and Calculation of CMS-416 Report – The intent of this project was to verify Arkansas EPSDT rates reported using HEDIS and the CMS-416 specifications. Both sources were reviewed and HSAG identified similarities and differences between the methodologies used for these reports. More specifically, the project examined the following two questions:

Arkansas

1) To what extent were the EPSDT rates in the CMS-416 report and the HEDIS 2009 report accurate according to the corresponding methodology?

2) What were the underlying factors that lead to differences between the reported EPSDT rates in the CMS-416 report and the HEDIS 2009 report?

- Geographic Variation in EPSDT Service Utilization – Using results from an analysis of EPSDT visits among Arkansas Medicaid children, HSAG evaluated the extent to which EPSDT service use varied by managed care arrangement and geographic variation. This analysis included a review of the impact on overall EPSDT rates due to the distance to the nearest provider.
- Hospital Readmissions – In coordination with the Arkansas Division of Medical Services, HSAG participated in a National Medicaid Medical Directors project evaluating 30-day readmission rates. Rates were evaluated for both OB and non-OB related omissions and stratified by key demographic variables.
- Foster Care Review – HSAG conducted an in-depth review of foster children with medically complex conditions. The results were used to identify the financial and service utilization impact of medical complex children and target areas for improving the quality of care.
- RSMI Review – HSAG continues to conduct a review of Arkansas' Rehabilitative Services for Persons with Mental Illness program. As a comprehensive profile of the RSMI program and its members, the results are being used to monitor program activities and target areas for improvement.

HEDIS Evaluation and Reporting

Per the contract HSAG will aggregate and evaluate HEDIS measures and produce and publish an annual HEDIS Booklet for SFY2009. This report will include thirteen HEDIS measures; twelve report administratively and one reported using the hybrid methodology. HSAG will perform the medical record data extraction for the *Childhood Immunization Status—Combo 2* measure. HSAG will also produce a HEDIS report containing measure results for SFY2010 by geographic region and beneficiary demographic.

Primary Care Physician (PCP) program and Emergency Room (ER) Usage Profiles

In the first year of the contract HSAG will provide DMS and Medicaid providers with utilization and performance data concerning the Primary Care Physician program and emergency room usage.

California	
Name of Contract:	**State of California** **Department of Health Care Services**
Primary Contact Person:	Susan Takeda Chief, Program Data & Performance Measurement Section California Department of Health Care Services (DHCS) 1501 Capitol Ave (Bldg 171); Suite 71.4049 Sacramento, CA 95899-7413 Phone: 916.449.5140 Fax: 916.449.5005 E-mail: Susan.Takeda@dhcs.ca.gov
Dates of Performance:	9/1/2008–6/30/2012
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG was awarded the External Quality Review contract by the California Department of Health Care Services (DHCS) in 2008. Under this contract, HSAG performs the following activities:

Audit and Reporting of External Accountability Set (EAS) Performance Measures

HSAG performs on-site, county-specific EAS compliance audits for the DHCS Medi-Cal Managed Care Program's selected HEDIS and department- developed performance measures. Under the contract HSAG produces:

- Preliminary and final plan-specific reports for 20 regular MCOs and 4 specialty MCOs.
- An aggregate report with detailed audit findings, analysis and recommendations; and, performance measure rate comparisons at the plan, county, state, and national level.

Evaluation of Quality Improvement Projects (QIPs)

HSAG performs QIP validation review, consistent with CMS protocols, of 2 QIPs for each of the 24 health plans. QIP projects include individual QIPs, small-group collaborative QIPs, and statewide collaborative QIPs.

HSAG produces quarterly QIPs Status Reports with analysis of validation results and QIP outcomes.

HSAG evaluates plan data and prepares remeasurement reports of the current statewide collaborative project aimed at decreasing avoidable emergency room visits. HSAG provides technical assistance and consultation to the State and plans related to collaborative QIPs.

HSAG developed a written description of HSAG's validation process and a *Quality Assessment Improvement (QIA) Guide* for plans. The *QIA Guide* provides guidance to health plans on designing a QIP project that meets CMS protocols and provides detailed instructions to health plans on QIP documentation.

California

Consumer Satisfaction Survey

HSAG administers the CAHPS® Medicaid survey for adults and children, analyzes results at the county-level, and produces plan-specific reports as well as a summary report.

Performance Evaluations

HSAG prepares plan-specific performance evaluation reports and an aggregate detailed Annual Performance Evaluation Report that describes the manner in which the data from all activities conducted in accordance with 42 CFR 438.358, were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and access to the care furnished by DHCS-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.

The annual report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Quality Improvement Conference

HSAG, in partnership with the DHCS, plans an annual quality improvement conference with the goal of presenting up-to-date, practical information to plans, State staff, and other key stakeholders, regarding quality improvement issues and best practices as they affect the managed care environment.

Colorado

Name of Contract:	**State of Colorado** **Department of Health Care Policy and Financing (DHCPF)**
Primary Contact Person:	Katie Brookler Strategic Projects Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, Colorado 80203-1818 Phone: 303.866.6173 Fax: 303.866.2083 E-mail: Katie.brookler@state.co.us
Dates of Performance:	7/1/08–6/30/13 The current contract is combined for Medicaid physical health, behavioral health and the state's Child Health Insurance Program. Previous contract period: 5/01/01–6/30/08 Prior to being combined in the current contract, these projects were awarded to HSAG in three (3) separate contracts.

Colorado

Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG is the external quality review organization (EQRO) for the Colorado Medicaid Managed Care Program and Children's Health Insurance Program – called Child Health Plan *Plus*, or CHP+. Duties include an independent external review of the quality of medical and behavioral health care and services provided to Colorado Medicaid and CHP+ clients, including the managed care organizations (MCOs), behavioral health organizations, (BHOs), Primary Care Physician Program (PCPP), and Unassigned Fee-For-Service (FFS) program.

Under this contract, HSAG:

Validates Performance Improvement Projects (PIPs), up to two PIPs for each MCO and BHO. HSAG assesses the plans' methodology for conducting the PIPs and evaluates overall validity and reliability of PIP results. HSAG reports the findings of the validation activity in individual MCO/BHO reports and also incorporates the information in the technical report.

Conducts Annual On-Site Compliance monitoring reviews for all of Colorado's Medicaid and CHP+ MCOs and BHOs to determine compliance with the access to care, structure and operation standards, enrollee rights and protections, and quality assessment and performance improvement regulations identified in the State's contract and the BBA managed care regulations. HSAG prepares individual MCO/BHO reports of findings, strengths, and opportunities for improvement. HSAG also incorporates data from the reviews into the annual statewide EQR Technical Report.

Conducts Annual HEDIS Calculation and Audit for the Medicaid PCPP and Unassigned FFS and CHP+ Self-Insured Network populations. HSAG provides 20 measures for the Medicaid PCPP and Unassigned FFS, 8 of which are calculated using the hybrid method. HSAG provides a total of seven measures for the CHP+ Self-Insured Network, two of which are hybrid.

The final audit includes a measure audit review, an evaluation of all measures calculated for the self-insured network population, and notification of reportable measures.

Prepares an Annual HEDIS Aggregate Report that includes rates for all physical health plans, PCPP, and Unassigned FFS. HSAG obtains HEDIS audit reports from the Medicaid MCOs to calculate a total Colorado Medicaid average. For each HEDIS measure, HSAG compares each MCO's level of achievement with state standards, Colorado Medicaid average, and national benchmarks to determine whether the results are statistically above, below, or not different from the average. The report includes an explanation of each measure and the HEDIS rates over the past three years with an analysis of the trends and any limitations for each measure.

Conducts on-site Validation of Performance Measure audit for each BHO, the PCPP, and the Unassigned FFS program in accordance with CMS protocols. HSAG produces individual reports for each BHO, the PCPP, and the Unassigned FFS and incorporates the results of the activity into the annual EQR Technical Report.

Colorado

Performs CAHPS Surveys for adults and children enrolled in the Medicaid PCPP and Unassigned FFS populations and the CHP+ program. HSAG annually conducts the surveys in both English and Spanish for the adult and child populations. HSAG administers the surveys in accordance with NCQA protocols. HSAG produces plan-specific reports annually for each population and produces an aggregate CAHPS report.

Prepares a detailed EQR Technical Report combining physical health and behavioral health that describes the manner in which the data from all EQR activities (compliance audits, PIP and PMV validation, HEDIS data), were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCOs/BHOs.

The technical report also includes an assessment of each MCO/BHO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Conducts individual case reviews referred by the State to address quality concerns. During the course of the EQR review, any potential quality-of-care concern is referred to an HSAG physician reviewer for determination.

Conducts credentialing and recredentialing activities for PCPP to ensure and validate that practitioners have the proper credentials in place to provide services. The process includes, but is not limited to, collection and verification of the status of licensure, validity of Drug Enforcement Agency (DEA) and/or controlled or dangerous substances (CDS) certification, relevant training and experience, board certifications, and work history. HSAG's responsibilities in this regard include administration of the credentialing program for current and future practitioners in the PCPP program and oversight and performance of the peer review functions of the credentialing process. The process used by HSAG closely parallels NCQA standards and guidelines for the accreditation of managed care organizations (MCOs).

OTHER ACTIVITIES:

Other activities conducted by HSAG throughout the course of its ten-year relationship with DHCPF include:

Conducted a behavioral health Encounter Data Validation (EDV) study in 2008 to evaluate the extent to which administrative encounters for behavioral health services were accurate and complete. The study focused on inpatient, outpatient, and physician/practitioner behavioral health encounters. Administrative encounters were evaluated for their completeness and accuracy via a health record review. The study employed a two-stage sampling method to extract administrative encounters for review. In the first stage, an oversample of members using institutional services was selected first for each BHO, then-members using non-institutional services were randomly selected so that the final sample reached a total of 411 members. In the second stage, one encounter was randomly selected for the validation for each sample member. HSAG certified coders conducted a review of all submitted documentation

Colorado

for the sample encounters to determine whether key data elements (i.e., date of service, date of birth, diagnosis, procedure, and unit) obtained from the electronic encounter file were present in the submitted behavioral health records. The coders also determined the accuracy of electronic encounter data based on documentation contained in the behavioral health record.

HSAG evaluated the extent to which proprietary crosswalks developed by the BHOs facilitated proper translation of home-grown procedure codes to Health Insurance Portability and Accountability Act (HIPAA) compliant codes; evaluated the prevalence of procedures in the administrative encounters submitted inconsistently or with unreasonable units; and examined the Information Systems Capabilities Assessment Tool (ISCAT) responses filled out by the BHOs and the Department to identify data quality-related issues identified in the State Medicaid Management Information System (MMIS).

Conduct Focused Studies. HSAG's participation included the development of a study question, study goals, sampling methodology, review methodology, study limitations, study tools, a data analysis plan, and a data reporting plan. For each focused study conducted, HSAG wrote a detailed report and incorporated the findings into the EQR Technical Report. Studies have included:

- Coordination of Care—Utilization of Services for Members Diagnosed With a Serious Mental Illness.
- Asthma Medication Management.
- Blood Lead Screening Intervention.
- Adolescent Well-Care (both qualitative and quantitative).
- Diabetes Quality-of-Care.
- Prenatal/Postpartum Care.
- Access to Preventive Care for Persons with Disabilities.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Development of Interventions—As part of its overall support, and based on results of the focused studies activities, HSAG collaborates with the State to develop and implement interventions. The purpose of intervention is to increase compliance with federal guidelines and to increase awareness among providers and beneficiaries and, thereby, improve the quality of care. Materials are developed to provide education and support for the providers and beneficiaries on a particular topic.

Each year, one or more interventions are chosen, on such topics as Blood Lead Screening, Preventive Services for Persons with Disabilities, Improving Pregnancy Outcomes, or EPSDT. The interventions include educational and awareness materials for providers and beneficiaries, such as posters for provider offices and refrigerator magnets with reminder postcards for beneficiaries.

The FY 10-11 activity was the Client Health Profile Pilot. This intervention was intended to improve service utilization among Colorado Medicaid beneficiaries. The pilot intervention targeted five groups of PCPP and FFS clients who had not received the preventive care

Colorado

recommended for their age, or recommended follow up for managing chronic health conditions during the first three quarters of 2010. Health profile letters were sent to individuals in each group that included general health information, screening recommendations based on the client's age, a recommended course of action for managing their particular condition (chronic condition or smoking) when the condition could be identified through claims data.

One of two FY 2009–2010 intervention projects aimed to improve the number of postpartum women who are screened for depression. HSAG provided participating providers with two postpartum depression screening tools (in both English and Spanish), instructions for administering the tools, available treatment resources for women identified as needing additional evaluation, and a letter for new mothers explaining the signs of postpartum depressions with numbers to call for help. The second intervention project strived to decrease the overuse and abuse of emergency departments by improving the number of Medicaid members who use the Nurse Advise Line (NAL). HSAG designed picture frame magnets and key fobs that advertise the NAL. These magnets and key fobs were distributed to high-volume providers. Providers were asked to distribute materials to Medicaid members with instruction on the appropriate use of emergency departments. HSAG will measure the effectiveness of this program by monitoring the volume of calls received by the NAL.

HSAG conducted a FY 2007-2008 prenatal and postpartum intervention survey for DHCPF. The goal of this intervention survey was to identify specific reasons why women did not receive timely prenatal or postpartum care.

For the EPSDT Intervention, DHCPF and HSAG initiated development of a Web page hosted on the State Web site that serves as a resource to providers and their office staff regarding the EPSDT program. The Web page was designed to be intuitive, easy to use, and educational, with non-duplicative information and quick links to new and established content. The page layout was organized into categories of general program information, health maintenance forms, visit tools, immunization tools, provider resources, parent resources, and billing codes. An announcement was included in newsletters and in the outreach packets produced by the State and health plans to notify Medicaid provider offices about the new Web page and its Web address.

HSAG assisted Colorado by preparing the quality improvement sections for its **Home and Community Based Services (HCBS) 1915(c) waiver applications** for the Elderly, Blind and Disabled; Brain Injured; and Child HCBS populations. The sections HSAG developed met Centers for Medicare & Medicaid Services (CMS) requirements for waiver applications as specified at (42 CFR 441.302). These requirements include assurances that the State has in place the necessary safeguards for the health and welfare of clients, performance of initial and ongoing service planning assessments, performance of initial and ongoing level of care reviews, and that client freedom of choice is maintained regarding choice of institutional or home and community based services.

To develop the quality improvement sections, HSAG interviewed State program administrators, reviewed and analyzed the Colorado Quality Strategy, the Evidentiary Based Reports (EBRs) for each of the waiver populations, and the CMS responses to the EBRs. In

Colorado

addition to the quality improvement sections, HSAG also developed a sampling methodology for the State's annual case file reviews to select an adequate number/percent of waiver specific cases for each regional contractor. Each waiver application included population specific performance measures the State could use to establish baseline data, and provided strategies the State could use in response to specific CMS recommendations.

HSAG's assistance to Colorado ensured that each of their waiver applications was compliant with federal regulations and would be effective in improving care processes for clients.

Florida

Name of Agency:	**State of Florida** **Agency for Health Care Administration (AHCA)**
Contact Person:	Lakia Daniels Contract Manager Florida Agency for Health Care Administration Medicaid Quality Management Bureau 2727 Mahan Drive Tallahassee, FL 32308 Telephone: 850.412.4675 E-mail: Lakia.Daniels@ahca.myflorida.com
Duration of Project:	5/1/06–6/30/12
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG provides external quality review (EQR) services for the Florida Medicaid managed care programs, administered by the Florida Agency for Health Care Administration (AHCA). As the EQRO, HSAG evaluates the quality, access, and timeliness of Medicaid services provided by the various contracted MCOs and Prepaid Inpatient Health Plan (PIHP) models in Florida, including Health Maintenance Organizations (HMOs), Prepaid Mental Health Plans (PMHPs), Nursing Home Diversion Plans (NHDPs), Provider Service Networks (PSNs), and the Statewide Inpatient Psychiatric Program (SIPP).

Under this contract, HSAG performs the following activities:

Reviews AHCA's monitoring of MCO Compliance with Access, Structural and Operational Standards in order to, among other things, ensure that the MCOs are adhering to established provider guidelines and that the MCOs are providing culturally competent care. In addition, HSAG assesses the communication strategy from the MCOs to providers and from providers to MCOs.

Validates MCO Performance Measures, in accordance with CMS protocols. HSAG provided AHCA with a report on the methodology for identification of bias in performance measures.

Florida

Validates Multiple Performance Improvement Projects (PIPs) for each MCO, using the current CMS protocols. HSAG produces a written report of findings and recommendations. HSAG evaluates the soundness and results of the PIPs implemented by the MCOs.

Conducts Exploratory Analysis on CAHPS Surveys upon request. HSAG conducts key exploratory analysis that guides improved methods for analyzing and reporting the data and provides suggestions for improving the strategic application for these surveys.

Prepares Strategic HEDIS Analysis Reports based on analysis and comparison of HEDIS performance measures submitted by each HMO and PSN. HSAG creates strategic reports to guide program evaluation, implementation, and quality improvement efforts.

Provides Technical Assistance: HSAG provides technical assistance to AHCA on the following activities, as needed: (a) Enrollee Race/Ethnicity and Primary Household Language Information, which includes a thorough review of the agency's current practices and procedures for collecting and transmitting race/ethnicity and primary language of Medicaid enrollees. Based upon the findings from this review, HSAG provides specific recommendations to AHCA to ensure compliance with BBA requirements, (b) Provides guidance and Technical Assistance on Value-Based Purchasing Methodologies, including strategies for developing and implementing incentives for superior performance, (c) Evaluates the AHCA Quality Strategy to determine the completeness of the quality strategy by examining strengths and limitations and recommends improvements in the description or implementation of the strategy, and (d) Conducts Focused Studies upon request. HSAG designs each study to include a thorough literature review, a study question, study goals, sampling methodology, review methodology, study limitations, study tools, a data analysis plan, and a data reporting plan.

Conducts and facilitates an Emergency Department Learning Collaborative: Through a collaborative, The Agency for Healthcare Administration (AHCA) and HSAG will work with key stakeholders including certain Health Maintenance Organizations (HMOs) and Provider Services Networks (PSNs), hospitals, community providers, patient advocacy organizations, and Medicaid consumers to reduce avoidable emergency department (ED) utilization. Many of the ED services utilized by Florida's Medicaid members are non-emergent and could be treated safely and effectively in an urgent or primary care setting.

AHCA is forming the ED Collaborative because there is a recognized need to address ED over-utilization at a systems level through a multifaceted approach that maximizes health care resources, encourages information sharing, and promotes community-specific solutions as essential elements in redirecting patients seeking avoidable care in the ED. This approach is the guiding principle adopted by the National Quality Strategy developed by the Department of Health and Human Services which is focused on national, state, and local efforts to improve health care quality on common aims, priorities and goals.

The objectives of the collaborative to reduce avoidable emergency department visits include:

- Improving care coordination and quality of care by directing users of the emergency department to the most appropriate care setting.

Florida

- Improving the effectiveness and efficiency of a community's health care resources by reducing emergency department visits that do not require an ED level of expertise and resource intensity.
- Promoting meaningful alternatives to emergency department utilization in an effort to build on the relationship between patients and primary care providers.
- Supporting improved communication between primary care providers, health care systems, emergency department providers, community providers, and HMOs/PSNs to facilitate shared patient information resulting in improved continuity of care.
- Establishing a collaborative to reduce avoidable ED visits with the HMO/PSN and work with local stakeholders to identify community-specific initiatives based on established best practices.
- Implementing initiatives identified by the collaborative in the next several months.

Provides Technical Assistance: HSAG provides technical assistance to MCOs/PIHPs to address specific activities related to compliance with the standards of the managed care rules developed under the BBA of 1997. This includes the development of tools, training, and technical assistance, in collaboration with AHCA and the MCOs/PIHPs, to be used for quality improvement activities.

Prepares a detailed EQR Technical Report that describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and access to the care furnished by AHCA-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Georgia	
Name of Agency:	**State of Georgia** **Department of Community Health**
Primary Contact Person:	Janice M. Carson, MD, MSA Deputy Director, Performance, Quality and Outcomes Georgia Department of Community Health Division of Medicaid 2 Peachtree Street, N.W. Atlanta, GA 30303-3159 Telephone: 404.463.2832 E-mail: jcarson@dch.ga.gov
Duration of Project:	7/1/08 – 6/30/13
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG was awarded the External Quality Review Organization (EQRO) contract by the Georgia Department of Community Health (DCH). DCH is responsible for the administration and oversight of the Medicaid managed care program in the State of Georgia. DCH contracts with three privately owned managed care organizations (MCOs) to deliver services to its members who are enrolled in its Medicaid managed care program and its Children's Health Insurance Program (CHIP). DCH refers to its three Medicaid managed care organizations as care management organizations (CMOs).

DCH contracted with HSAG to annually conduct a quality review of CMO performance for the three mandatory Medicaid activities; prepare an annual report of results, as federally required; and conduct a conference for DCH, the CMOs, and when specified by DCH other stakeholders. The three mandatory activities include a review and evaluation of the CMOs' compliance with federal Medicaid managed care regulations and the associated State contract requirements; validation of the DCH-selected CMO performance improvement projects (PIPs); and validation of the DCH-specified CMO performance measures.

HSAG's processes for conducting each of the DCH-contracted annual activities are described briefly below. HSAG follows the CMS protocols for conducting the CMS mandatory and optional activities.

Validation of Performance Improvement Projects (PIPS)

Evaluate the soundness and results of the PIPs implemented by each of the three CMOs, and produce individual CMO reports for DCH and the CMOs. The reports encompass HSAG's findings from conducting the PIP validation activities, and recommendations to improve the validity of the CMOs' PIP processes and, as applicable, performance on the measures.

Validation of Performance Measures (PM)

Evaluate the accuracy of PMs reported by the CMOs and determine the extent to which PMs calculated by the CMOs followed specifications established by DCH for the calculation of the measures and results of associated PIPs implemented by the CMOs. HSAG produces for DCH

Georgia

and the CMOs a CMO-specific report of performance results. HSAG also provides to DCH an annual statewide summary report of performance across the CMOs and recommendations to improve performance.

Review of CMO Compliance with Specified Standards for Quality Assessment and Performance Improvement Program Operations

Using a combination of document review and interviews with CMO personnel, assess the CMOs' compliance with the DCH contract and federal Medicaid managed care requirements/standards for the quality and timeliness of, and access to care and services that promote safe and effective health care. HSAG produces a CMO-specific report for DCH and the CMOs that encompasses its findings from the review of compliance. The individual reports include: a summary of the CMO's strengths and when applicable, opportunities to improve performance; presentation of the performance results and scores for each standard (set of related requirements) reviewed; a description of HSAG's methodology for preparing for and conducing the reviews; and, as applicable, a template for the CMO to use in preparing its corrective action plan for any requirement where performance was scored as less than a *Met*.

Conduct an EQR Conference

After issuing the EQR reports for each activity, conduct a conference for DCH, the CMOs, and other constituents identified by DCH to present the results of having conducted the EQR mandatory activities and/or to provide information to DCH and the CMOs related to strategies and best practices for improving performance in one of more DCH-selected high priority areas. HSAG works collaboratively with DCH to identify the focus, content, and audience for each annual conference.

Prepare an Annual EQR Technical Report

Prepare a detailed annual EQR technical report that described the manner in which the data from all activities HSAG conducted in accordance with 42 CFR 438.358 were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the CMOs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. The annual EQR report also includes an assessment of each CMO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to their members; and recommendations to improve performance and member health outcomes. After the first contract year, the EQR annual report has also included an assessment of the degree to which each CMO addressed effectively the performance improvement recommendations HSAG made during the previous year's review processes.

CMS Optional EQR Activities And DCH-Selected Special Projects

CMO Guide: For the first year of the contract, in addition to the annual activities, DCH also contracted with HSAG to prepare an EQR guide for the CMOs that provided information about the federal Medicaid managed care requirements, the role of an EQRO, and information about HSAG. The guide outlined HSAG's processes to determine CMO performance related to each of the activities HSAG would conduct and described the respective responsibilities of

Georgia

DCH, HSAG, and the CMOs in preparing for and conducting the EQR activities.

Encounter Data Validation, Collaborative PIP, and Quality-Based Auto-Assignment: In Contract Year II, in addition to the DCH contracted annual activities described above, DCH contracted with HSAG to conduct one CMS-specified Optional Activity (i.e., Encounter Data Validation) and two special projects [(i) Facilitating a Collaborative PIP among the three CMOs and the State; and (ii) developing and providing to DCH a Quality-Based Member Auto Assignment Algorithm]. HSAG followed the CMS protocol for conducting the encounter data validation activity and provided a report of its findings to DCH.

For Contract Year III, in addition to the annual activities, DCH contracted with HSAG to continue the Auto-Assignment Project by deriving the auto assignment weights/scores by region for each CMO based on the prior year's validated HEDIS and AHRQ performance measures and providing the scores to DCH.

Hawaii

Name of Agency:	**State of Hawaii** **Department of Human Services** **Med-QUEST Division**
Primary Contact Person:	Chris Butt Contract Monitoring & Compliance Section Hawaii Department of Human Services, Med-QUEST Division 601 Kamokila Boulevard, Room 506B Kahuhihewa Kapolei State Building Kapolei, HI 96707-2021 Telephone: 808.692.8165 E-mail: cbutt@medicaid.dhs.state.hi.us
Duration of Project:	7/01/01–12/31/12
Cost of Project:	[redacted]

Description of Current Services Performed and Deliverables:

HSAG provides external quality review (EQR) services for the QUEST and QExA programs for the Department of Human Services, Med-QUEST Division (MQD), as well as Peer Review Organization (PRO) services for the Fee-For-Service (FFS) and managed care populations.

Hawaii EQR services include:

Conducts a CAHPS Survey for adults and children enrolled in the Medicaid managed care health plans. HSAG conducts the survey annually for the MCOs and alternates between the adult and child CAHPS Surveys. HSAG administers the surveys in accordance with NCQA protocols. HSAG produces plan-specific and aggregate reports annually.

Conducts a HEDIS Audit Validation Study with the MCOs. Measures have included:

Hawaii

- Childhood Immunization.
- Comprehensive Diabetes Care.
- Ambulatory Care – ER and Outpatient Visits per 1,000 Members.
- Cholesterol Management for Patients with Cardiovascular Conditions.
- Breast Cancer Screening.
- Chlamydia Screening.

Monitors Compliance of MCOs through on-site reviews to determine their compliance with Medicaid managed care regulations and State requirements in the following areas:

- Enrollee rights and protections.
- Access standards.
- Structure and operational standards.
- Quality Measurement and Improvement
- Grievance system.

Reviews MCOs' Corrective Action Plans (CAPs) for any standards not fully compliant. HSAG provides the MCOs with a CAP template that identifies the areas needing to be addressed. Following receipt and review of the CAP, HSAG provides feedback to the Med-QUEST Division and the MCOs regarding the likelihood of the CAP resulting in compliance.

Conducts a Re-Evaluation of the CAP Implementation by the MCOs to review their progress in bringing into compliance any standards found less than fully compliant.

Provides Technical Assistance to the MQD and MCOs to address questions and specific expectations for their participation in the external quality review activities. In addition, HSAG provides assistance to the MQD on a variety of special projects, such as preparation of a consumer guide, review and feedback on survey instruments under development, review and feedback on the State's quality strategy, etc.

Validates Performance Improvement Projects (PIPs) for each of the MCOs. Using the current CMS protocols, HSAG evaluates the soundness and results of two of the PIPs implemented by the MCOs, and produces a written report of findings and recommendations.

Conducts a Provider Satisfaction Survey of the primary care physicians (PCPs) and high-volume specialty physicians for each MCO every other year. HSAG is responsible for survey methods and design, survey production, administration, and data analysis. HSAG prepares a written report of survey results.

Prepares a detailed EQR Technical Report that describes the manner in which the data from all mandatory and optional activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by Med-QUEST-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. The technical report also includes an assessment of each

Hawaii

MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each plan; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Additional Services that have been provided under contract with the DHS/MQD include Development of Deeming Strategy Recommendations, HEDIS Consumer Guide development, encounter data validation study, and technical assistance to and training of the MQD on EQR-related and quality improvement topics.

HSAG provides **PRO services for the FFS and managed care population** in Hawaii, which include the following three components:

The **Acute Care Hospital/Ambulatory Surgery Center Review** is based on a State-selected sample of paid medical and psychiatric hospital claims or encounters for QUEST and QExA program recipients. The sample includes a selection of:

- Ambulatory surgery reviews.
- Acute hospital admissions with lengths of stay in excess of 10 days.
- Cost outliers.
- Readmissions within 30 days with the same/similar diagnosis.
- Additional cases selected by the MQD for review.

Using InterQual criteria, the registered nurse reviewers assess the following as it pertains to dates of service and/or place of service:

- Appropriateness of length of stay.
- Appropriateness of place of service.
- Appropriateness of LOC.
- Appropriateness of services rendered.
- Quality issues.
- Recommendations on monitoring activities.
- Identification of recoveries of any over-payments.

Conducts PASRR Compliance Reviews based on information from the medical record, including the resident's history and physical, physician's order sheets, consultations, minimum data sets (MDS), medication administration records, and care plans. The purpose of these reviews is to determine the degree to which Hawaii's Medicaid-certified nursing facilities comply with the federal regulations for screening admissions to nursing facilities. A sample of cases for review is provided by the State. Registered nurses perform the reviews and HSAG reports all findings of noncompliance to the State monthly for follow-up, and provides an annual summary report of findings.

Conducts Long Term Care (LTC) Level of Care (LOC) Evaluations and Determinations

Hawaii

on assessments of Medicaid recipients who may require long-term care services in nursing facilities or from home and community based (HCBS) service- providers. Each LOC request is evaluated by a Hawaii-licensed registered nurse, utilizing a combination of clinical information and functional scores, to arrive at an LOC determination. On average, one thousand LOC determinations are processed every month.

Maintains the LTC LOC Determinations Database in Hawaii. HSAG works closely with DHS/MQD to assure the database developed for the LTC LOC determinations information meets the needs of DHS and produces the results and reports desired. HSAG has developed a secure Web application, HILOC, for this purpose. Accessible to registered users from the State, Medicaid health plans, and LTC service providers, HILOC provides an electronic mode of submission and review/approval of LTC LOC requests. HILOC interfaces with the State's prepaid medical management information system, and is able to provide the necessary information to produce monthly, quarterly, annual, and ad hoc reports. Following HSAG's training on HILOC to the provider community, electronic submission quickly increased to 95 percent, as opposed to use of paper faxed requests, and HSAG has received numerous positive comments about the HILOC application.

Illinois

Name of Agency:	**State of Illinois** **Department of Health and Family Services (HFS)**
Primary Contact Person:	Ellen Amerson MCO Operations and Quality Department of Healthcare and Family Services (HFS) 607 East Adams, 4th Floor Springfield, IL 62701 Telephone: 217.558.1297 E-mail: Ellen.Amerson@illinois.gov
Duration of Project:	6/30/06–12/31/12
Cost of Project:	[redacted]

Description of Current Services Performed and Deliverables:

The Illinois Department of Health and Family Services (HFS) contracts with HSAG to conduct an independent external quality review (EQR) of the quality improvement (QI) activities of the State's MCOs including the Integrated Care Program (ICP).

HSAG conducts the following activities for this contract:

Validates MCO Performance Measures and NCQA HEDIS Compliance Audits™ of MCOs, in accordance with CMS protocols. This includes an on-site review of each MCO. HSAG uses the hybrid methodology to validate the following performance measures:

- Childhood Immunization Status.
- Well-Child Visits in the First 15 Months of Life (and under age 3).

Illinois

- Preventive Care for Women.
- Prenatal and Postpartum Care.
- Appropriate Care for Persons with Chronic Illnesses, such as Asthma and Diabetes.

Conducts a Validation of Performance Measures for the Primary Care Case Management Program (PCCM) administered by HFS and in accordance with the CMS protocols for validating performance measures. The validation of performance measures provides findings related to 15 performance measures, and includes the general steps for appropriately calculating and reporting the performance measures. Comments for each individual performance measure will also be provided to HFS program staff. This audit includes an on-site review of the State's information system and a review of the processes used to collect and calculate the PCCM performance measures. In addition, HSAG provides technical assistance in the revision of the technical specifications used by HFS to collect and report the performance measures.

Conducts a Validation of Performance Measures for the Integrated Care Program (ICP), in accordance with the CMS protocols for validating performance measures. The validation of the ICP performance measures provides findings related to ICP performance measures, and includes the general steps for appropriately calculating and reporting the performance measures. This audit includes an on-site review of the State's information system and a review of the processes used to collect and calculate the baseline ICP performance measures. In addition, HSAG provides technical assistance in the revision of the technical specifications used by HFS to collect and report the performance measures.

Conducts a Validation of Performance Measures for the Children's Health Insurance Program Reauthorization Act (CHIPRA), in accordance with the CMS protocols for validating performance measures. The validation of the CHIPRA performance measures provides findings related to CHIPRA performance measures, and includes the general steps for appropriately calculating and reporting the performance measures. This audit includes an on-site review of the State's information system and a review of the processes used to collect and calculate the CHIPRA performance measures. In addition, HSAG provides technical assistance in the revision of the technical specifications used by HFS to collect and report the performance measures.

Provided technical assistance to HFS in the development of Performance Measures for the Integrated Care Program (ICP) - The ICP serves approximately 40,000 seniors and adults with disabilities who are eligible for Medicaid but are not eligible for Medicare. HSAG worked with HFS and the ICP health plan staff to select performance measures applicable to seniors and adults with disabilities. Measures included both HEDIS and State developed performance Measures. HSAG developed the technical specifications for the performance measures. HSAG also provides annual technical assistance to update the technical specifications.

Validates Performance Improvement Projects (PIPs), in accordance with the CMS protocols for validating PIPs. One of the PIPs will be performed as a collaborative project among all of the MCOs, with consultation assistance provided by HSAG. HFS, in conjunction

Illinois

with the MCOs and HSAG, determines the focus of the PIP. This consultation assistance includes quarterly face-to-face meetings between HSAG and the MCOs for the purpose of providing consultation and ongoing monitoring of the progress of the collaborative PIP. Periodic telephone conference calls will supplement the quarterly face-to-face meetings with HFS and the MCOs.

Conducts Quality Assurance Program Compliance Review of each MCO to determine compliance with federal managed care regulations using CMS' *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.*, Final Protocol Version 1.0, February 11, 2003. The full, comprehensive review is completed every three years.

Conducts Focused Reviews of the Quality Assurance Program of each MCO to determine compliance with a specific component or components of the MCOs compliance with state and federal regulations.

Conducts Readiness Reviews for new plans that enter the program. HSAG conducts Readiness Reviews within 30 days of the request by HFS. The Readiness Review will assess the new MCO for compliance with the State of Illinois, HFS' Contract for Furnishing Health Services by a Managed Care Organization. Prior to enrollment of each new MCO, HSAG will determine whether the MCO's internal monitoring processes are sufficient for assuring ongoing compliance with contract requirements, quality oversight, and monitoring of the Quality Assurance Plan (QAP). One year after the MCO has entered the program, HSAG will conduct an assessment of the adequacy of the MCO's QAP and ongoing monitoring of the MCO's implementation of its QAP, including the MCO's development and implementation of quality improvement plans. Most recently HSAG conducted readiness review for the Chicago REACH Program to determine the program's readiness to implement a PIHP program. In addition, HSAG also conducted a readiness review of the Integrated Care Program health plans and their readiness to accept enrollment of seniors and disabled members.

Conducts Information Systems Readiness Review of existing MCOs to review the data management processes of the MCO; review and assess the procedures the MCO has in place for collecting and integrating medical, financial, member and provider information, covering clinical and service-related data from internal and external sources.

Participates and Facilitates the Monthly MCO and ICP quality conference calls with HFS to discuss the status of the plans activities in reference to their quality programs, performance improvement project, performance measures..

Participates in the States Quarterly Quality Improvement Committee meetings with HFS staff the MCOs, and ICP plan medical directors and quality program staff. The meetings include discussion of compliance with the State's quality strategy and ongoing monitoring of performance of the MCO and ICP programs. The committee is also responsible for oversight of the State's Collaborative Performance Improvement Projects (PIPs).

Conducts an Overall Evaluation of the Quality Strategy annually to determine HFS'

Illinois

compliance with the requirements of 42 CFR 438.204 and to make recommendations to HFS on the effectiveness of its Quality Strategy. This activity includes HSAG's participation in an annual quality assurance meeting convened by HFS to review the Quality Strategy with stakeholders, providers, and MCOs.

Provides ongoing Technical Assistance, as directed by HFS, to each MCO on its implementation of quality assurance activities. HSAG makes appropriate recommendations to HFS on the need for MCO-specific technical assistance. Based on the technical assurance plan, HSAG provides a report to HFS detailing the technical assistance provided to the MCO and the actual outcome or benefits of the technical assistance.

Assists with the Development of the MCO Pay-for-Performance Program (P4P), HSAG worked with HFS to provide technical assistance in the development of the P4P including selection of the measures and development of minimum and high performance targets based on national HEDIS benchmarks.

Assists with the Development of an MCO Performance Tracking Tool, HFS and HSAG created a PTT for each MCO. The PTT was initially designed as a mechanism for the State and the MCOs to monitor and trend the results of each performance measure identified in the tool. The PTT was used to record baseline and remeasurement results for each performance measure, and to identify how the plan is performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period.

Conducts Focused Quality Studies of service delivery and utilization and Special Projects in areas identified by HFS. To support HFS' quality improvement efforts, HSAG will make recommendations for studies throughout the term of the contract.

For each focused quality study, HSAG develops and submits written procedures to HFS for conducting the study in order to identify service utilization patterns and trends, quality of care concerns, and program needs and potential for program enhancements. These written procedures will include a comprehensive plan that describes the planning, recommended sampling methodology, implementation, initial study, and follow-up study design. HSAG understands that a focused quality study includes a medical record review and analysis of administration data to answer a specific question of relevance to the population about the quality of care delivered.

Drawing upon its knowledge of Medicaid managed care and the specific issues facing the Illinois MCOs, HSAG identifies one or more special projects designed to improve quality of care. Such projects might include research and reporting on "pay for performance" strategies other states use in managed care that have proven successful in improving performance measures or health status; research and reporting on states' "best practice strategies" for compliance with HEDIS measures at the Medicaid HEDIS 75th percentile; development of a medical record abstraction tool for the purpose of conducting a focused quality study; or development of Web-based provider education materials that have been recommended as a result of the focused quality study results. For each special project, HSAG will develop and submit written procedures to HFS for the project to identify program needs and potential for program enhancements and recommendations regarding quality of care or establishing level of

Illinois

care criteria, at the sole discretion of and as directed by HFS.

Performance Improvement Projects - Three PIPs have evolved into **Ongoing Statewide Collaboratives** between HFS, the HFS MCOs and HSAG.

- **EPSDT**—In state fiscal year (SFY) 2004–2005, HFS and the HFS MCOs collaborated to conduct a PIP designed to review EPSDT services provided in Illinois. The main purposes of this EPSDT PIP was to establish baseline rates and to determine to what extent EPSDT services were being provided to HFS MCO members. The health plans are currently in the intervention phase of this PIP. This phase includes planning both provider and member interventions. As part of this intervention phase, the health plans began a collaborative EPSDT provider survey to help identify potential educational and outreach efforts that could be implemented for their providers. The survey was completed in the summer of 2007, and further enhancements to the health plan interventions should be implemented in the fall of 2007. The first remeasurement period occurred in 2008, for children who turn 36 months of age by December 31, 2007. Subsequent remeasurement will occur until sustained improvement in the PIP outcomes is demonstrated.
- **Perinatal Care and Depression Screening**—The primary purposes of the Perinatal Care and Depression Screening collaborative PIP were to determine baseline rates for three perinatal HEDIS measures, the prevalence of depression screening among pregnant women, and the rate of follow-up for women who screened positive for depression. Findings revealed that interventions should largely focus on provider education, including documentation and medical coding for various aspects of perinatal care and depression screening. The health plans are currently in the intervention phase of this PIP. This phase includes planning both provider focused and member focused interventions. The interventions should be fully implemented throughout contract year (CY) 2007. The first remeasurement period occurred in SFY 2008, for women who have a live birth between November 6, 2006, and November 5, 2007. Subsequent remeasurements will occur until sustained improvement in the PIP outcomes is demonstrated.
- **Follow up after Hospitalization for Mental Illness and PCP Communication** - Appropriate treatment and follow-up of mental illness can reduce the duration of disability and the likelihood of recurrence. The first remeasurement period occurred in SFY 2008. Subsequent remeasurements will occur until sustained improvement in the PIP outcomes is demonstrated.

Performance Improvement Projects – HSAG provides technical assistance to HFS and the HFS ICPs in the development of a Collaborative PIP. This PIP's focus involves medically high-risk members with a recent hospital discharge who are actively receiving Care Coordination with linkage to Community Resources. This PIP will explore the relationship between Care Coordination in conjunction with community resources and hospital readmission rates less than 30 days post discharge.

Prepares a detailed EQR Technical Report that describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care

Illinois

furnished by HFS-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Conducts EPSDT Provider Survey - the EPSDT Provider Survey was conducted during the intervention phase of the HFS MCOs' statewide EPSDT collaborative PIP which focused on the delivery of EPSDT services to HFS-enrolled beneficiaries in the State of Illinois. The purpose of the EPSDT Provider Survey was twofold:

- To assess primary care practitioners' (PCPs') knowledge regarding the components for documentation and coding of EPSDT services.
- To identify potential targets for additional performance improvement activities.

The EPSDT Provider Survey was designed to identify barriers PCPs may encounter in delivering EPSDT services to the HFS MCO population. Results from the survey will be used to identify additional interventions that could potentially improve EPSDT rates.

Monitors the Corrective Action Plans (CAPs) for compliance review and performance measures.

Michigan

Name of Agency:	**State of Michigan** **Department of Community Health**
Primary Contact Person:	Sheila Embry, BSN, RN, MBA/HCM Manager, Quality Improvement & Program Development Medical Services Administration Michigan Department of Community Health 400 S. Pine, 7th Floor P.O. Box 30479 Lansing, MI 48909-7979 Telephone: 517.335.5270 E-mail: embrys@michigan.gov
Duration of Project:	9/18/04–10/31/12
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG provides external quality review (EQR) services for the Michigan Department of Community Health's Managed Care Plan Division (MCPD). The MCPD is responsible for the

Michigan

administration, quality oversight, and performance monitoring of the Medicaid Comprehensive Managed Care Program. MDCH has contracts with 14 health plans, referred to as Medicaid Health Plans (MHPs) and 10 State Children's Health Insurance Plans, called MIChild Contractors. Under this contract, HSAG:

Validates PIPs, including an assessment of the MHP's methodology for conducting the PIP and evaluation of overall validity and reliability of study results. For each of the 14 MHPs, HSAG validates one PIP on the state selected topic, such as breast cancer screening disparity or cervical cancer screening disparity. Following completion of the validation activities, HSAG produces individual reports of the findings. HSAG also incorporates the results in the annual EQR Technical Report.

Reviews and analyzes Medicaid NCQA HEDIS Compliance Audit™ Reports, reviews Medicaid HEDIS IDSS results, and develops a comprehensive statewide written report presenting an analysis of NCQA HEDIS Compliance Audit™ Reports with recommendations for improvements. MDCH requires each of the 14 MHPs to collect and report a set of Medicaid HEDIS measures. HSAG performs an independent evaluation of the audit results and findings to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by or on behalf of the MHP followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures is performed, as well as a thorough information system evaluation, to assess each MHP's support systems available to report accurate HEDIS measures. Deliverables include the HEDIS Database and Graphs Report and Statewide aggregate HEDIS analytical report.

Prepares a detailed EQR Technical Report that describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MHPs. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Performs an analysis of HEDIS data, including CAHPS 4.0H Surveys, from 14 Michigan MHPs for presentation in the Michigan Medicaid Consumer Information Guide. To accomplish this, HSAG compares individual plan rates with the average rate of the aggregate of the plans. Plans are then given "stars" based on their performance (above average, average, or below average). HSAG also provides MDCH with a supplemental analysis for the Performance Bonus program. HSAG identifies positive outliers for MDCH on specific

Michigan

CAHPS questions that feed into the Performance Bonus.

For the Michigan MIChild program, HSAG produces a technical report that provides overall statewide and plan-specific findings for the seven medical and three dental contractors. The report addresses findings from the compliance site visits conducted by MDCH to assess contractors' compliance with contractual requirements and results of the validation of performance measures activities for MDCH and the medical MIChild contractors.

Michigan

Name of Agency:	**State of Michigan** **Department of Community Health** **Mental Health and Substance Abuse Administration**
Primary Contact Person:	Kathleen Haines MDCH Contract Administrator Division of Quality Management and Planning Behavioral Health and Developmental Disabilities Administration Department of Community Health Lewis Cass Bldg. 320 S. Walnut Lansing, MI 48913 Telephone: 517.335.0179 E-mail: haineskat@michigan.gov
Duration of Project:	7/1/04–10/31/12
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

HSAG provides EQR services for the 18 Prepaid Inpatient Health Plans (PIHPs) in Michigan's Community Mental Health System for Medicaid beneficiaries. The PIHPs are carved out from the State's MHPs to manage the specialty services benefit for persons with a mental illness, developmental disability, or addictive disorder.

Conducts activities to determine compliance with Medicaid Managed Care Regulations using CMS protocols. HSAG conducts reviews of the 18 PIHPs to determine the degree to which the PIHPs comply with their MDCH contract requirements and the BBA managed care regulations. HSAG prepares individual reports of findings, strengths, and opportunities for improvement. HSAG also incorporates data from the reviews into the annual EQR Technical Report.

Validates performance measures in accordance with CMS protocols. HSAG validates a set of 14 performance indicators developed by MDCH. Working in collaboration with MDCH and PIHP participants, HSAG customizes the Information Systems Capabilities Assessment Tool (ISCAT) to collect the necessary data consistent with Michigan's mental health service delivery model. HSAG's validation activities include an on-site review of each PIHP. HSAG conducts site visits to each PIHP to validate the processes used to collect performance data and report the performance indicators. The on-site visits include: an assessment of information systems, claims

Michigan

and encounters processing, recipient and provider data, a review of the ISCAT and supporting documentation, a review of processes used for collecting, storing, validating, and reporting the performance measure data. Following completion of the validation activities, HSAG produces individual reports of the findings. HSAG also incorporates the results in the annual EQR Technical Report.

Validates PIPs, including an assessment of the PIHP's methodology for conducting the PIP and evaluation of overall validity and reliability of study results. For each of the 18 PIHPs, HSAG validates one PIP on the statewide topic, "Improving the Penetration Rates for Children." Following completion of the validation activities, HSAG produces individual reports of the findings. HSAG also incorporates the results in the annual EQR Technical Report.

Produces an EQR Technical Report summarizing each of the three mandatory activities: Compliance with Standards, Validation of Performance Measures, and Validation of PIPs.

In the EQR Technical Report, using findings from these three activities, HSAG provides an assessment of the PIHPs' strengths and weaknesses and makes recommendations for improving the quality, timeliness, and access to care provided.

Nevada

Name of Agency:	**State of Nevada** **Division of Health Care Financing and Policy**
Contact Person:	John Whaley Chief of Business Lines Division of Health Care Financing and Policy 1100 East Williams Street, Suite 101 Carson City, NV 89701 Telephone: 775.684.3691 E-mail: jwhaley@dhcfp.nv.gov
Duration of Project:	7/1/99–6/30/13
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

Performs annual Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audits of MCOs and produces plan-specific and aggregate comparative reports.

Validates Performance Improvement Projects (PIPs) using the current CMS protocols and produces a written report of findings and recommendations. HSAG evaluates the soundness and results of the PIPs implemented by the MCOs. HSAG also facilitates and Manages a Blood Lead Screening in Children Collaborative PIP. HSAG provides technical assistance for the collaborative lead screening PIP, and produces an aggregate report with recommendations designed to enhance improvement efforts conducted by the MCOs.

Performs Validation of Performance Measures and NCQA HEDIS Compliance Audits™ of MCOs to validate the Health Insurance Flexibility and Accountability (HIFA) waiver performance measures.

Nevada

Performs Validation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy (QAPIS) to evaluate the completeness and effectiveness of the QAPIS and determine the extent to which the DHCFP, in concert with its contracted MCOs, has implemented the methods described in the QAPIS for assessing MCO compliance with CMS quality standards.

Conducts a Comprehensive Evaluation of the Internal Quality Assurance Program (Every Three Years) of each MCO's compliance with the Medicaid Managed Care contract and the Nevada Check-Up contract and BBA requirements. Produces a plan-specific report of findings and recommendations.

Prepares a Detailed EQR Technical Report (Annual) that describes the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by DHCFP-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients; recommendations for improving the quality of health care services provided by each MCO; and an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Provides Ongoing Technical Assistance and Presentations to DHCFP and the MCOs for performance measures development and contract compliance with BBA requirements.

At the request of DHCFP, HSAG's contract also includes the following optional activities:

Review of Fee For Service (FFS) Medicaid Population, which include: clinical focused studies, HEDIS or HEDIS-like calculations and audits, encounter data validation and omission studies, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

Review of DHCFP Care Coordination Vendor, which include a comprehensive on-site compliance audit and validation of the performance measures.

Review Activities for a New Medicaid Aged, Blind, and Disabled (ABD) Managed Care Program, which include consulting in the development of performance measures applicable to the ABD population, an information systems readiness review on the selected ABD MCO vendor, and evaluation of the implementation of performance measures.

Review Activities for an Expanded Managed Care Program in Rural Areas, which include consulting in the development of performance measures, an information systems readiness review on the selected MCO, provide technical assistance to the MCOs on the development of performance measures, and conduct a HEDIS compliance audit or validate the measures using the CMS Validating Performance Measures protocol on the contracted MCO.

Ohio	
Name of Agency:	**State of Ohio** **Ohio Department of Job and Family Services**
Primary Contact Person:	Kara Miller Chief, QA/Performance Improvement and Care Management Section Bureau of Managed Care (BMC) Office of Ohio Health Plans 50 West Town Street, Suite 400 Columbus, OH 43215 Mailing Address: PO Box 182709 Columbus, OH 43218-2709 Telephone: 614.752.4826 E-mail: kara.miller@jfs.ohio.gov
Duration of Project:	10/1/03–6/30/13
Cost of Project:	[redacted]

Description of Current Services Performed and Deliverables:

HSAG is the designated external quality review organization (EQRO) and provides external quality review (EQR) activities for Medicaid enrollees in both the managed care and Fee-For-Service (FFS) delivery systems for the Ohio Department of Job and Family Services (ODJFS). Under this contract, HSAG provides the following services:

Conducts an Evaluation of Administrative Processes and Compliance. HSAG conducts on-site reviews of seven managed care plans (MCPs) to evaluate compliance with federal and state-specific regulations to include the BBA, the Ohio Administrative Code, and the Ohio Medical Assistance Provider Agreement for Managed Care Plans (Provider Agreement).

Conducts Focused Studies of Clinical Health Care Quality. In the past, the studies included Medicaid managed care members and recipients in the FFS program. In state fiscal year 2006, the state expanded the Medicaid managed care program statewide. Studies now include the covered families and children (CFC) and the aged, blind, and disabled (ABD) populations. All studies are conducted using a hybrid methodology. Topics include:

- Childhood Immunizations
- Asthma
- Perinatal Care
- Abortion, Sterilization, Hysterectomy
- Adolescent Health Care
- Childhood Lead Screening
- Smoking Cessation
- Case Management
- Women's Preventive Health
- Ohio Healthchek (Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] Program)

Ohio

Conducts Encounter Data Validation Studies that focus on measuring the accuracy of delivery encounters to verify that MCPs submit encounter data accurately to receive appropriate payments from the state for prenatal and postpartum care.

Conducts Encounter Data Omission Studies that focus on the accuracy of encounters submitted to the state. The study compared six months of encounters in members' medical records to the encounters sent to ODJFS.

Conducts Encounter Data Validation Studies of Payment Encounters to measure the accuracy of payment information submitted on encounter data for each MCP participating in the CFC and/or ABD program. HSAG provides technical assistance to the MCPs that either perform poorly on the annual encounter data studies and/or are found to maintain poor data quality.

Conducts Validation of Performance Measures identified by ODJFS for each MCP. HSAG produces an annual report that allows plan-to-plan comparisons and comparisons to national benchmarks. HSAG follows CMS protocols to evaluate performance measures.

Conducts Calculation and Development of ODJFS Access and Clinical Performance Measures for the CFC and ABD programs. HSAG performs ODJFS algorithms and provides access to, and technical assistance on, HSAG's coding. Based on national standards or best practices, HSAG recommends measures, benchmarks, performance standards, and methodological improvements. HSAG also provides ad hoc research, analytical, and technical support as needed.

Conducts Validation of Performance Improvement Projects for the MCPs to ensure that PIPs are designed, conducted, and reported in a methodologically sound manner. Using the current CMS protocols, HSAG validates Performance Improvement Projects for each of the MCPs and produces written reports of findings and recommendations. HSAG evaluates the methods and results of the Performance Improvement Projects implemented by the MCPs.

Performs CAHPS Surveys annually for adult, child, and children with chronic conditions (CCC) enrollees for each MCP. HSAG conduct surveys according to NCQA protocol. HSAG produces plan-specific and aggregate reports for each population.

Conducts Reviews of MCP Information Systems for each health plans when requested by ODJFS.

Conducts MCP Information System Readiness Reviews for new health plans entering the Ohio Medicaid market to ensure that the MCP can properly accept the state's data; process claims; submit encounter information; process capitation; receive and process member files; follow care management and prior authorizations; 24-hour call center, provider relations, and member services.

Conducts Evaluations of Care Coordination and Continuity of Care by reviewing and evaluating the utilization management programs for pharmacy, prior authorization requirements for specific drugs, preferred drug lists, the pharmacy restriction program, and the emergency department diversion programs.

Ohio

Evaluates Care Management processes and procedures conducted by the MCPs to ensure compliance with the BBA, the Ohio Administrative Code, and the Provider Agreements. Reviews include specific requirements established for the Children with Special Health Care Needs program.

Develops Collaborative Models for Performance Improvement Projects. Implementation of a standardized Performance Improvement Project to address clinical and non-clinical areas of importance as specified in the CMS protocols.

Planned, Conducted and Facilitates Collaborative Learning Project, through development of **IMPROVE** (Implement Medicaid Programs for the Reduction of Avoidable Visits to the ED) is a statewide collaborative that brought together key stakeholders such as health systems, community leaders, emergency departments, health care providers, managed care plans, and consumer and family advocates. During the past 18 months, IMPROVE Regional Steering Committees in five principle cities (Toledo, Cincinnati, Columbus, Akron, and Cleveland) successfully developed and implemented community-specific initiatives across the State of Ohio, involving key care continuum providers and Medicaid members. These patient-centered quality interventions addressed region-specific health conditions that have high avoidable ED use. Categories include Severe Mental Illness, Chronic Back Pain, Ultra Utilizers and Dental Conditions. In addition, the regional committees joined forces to launch a statewide effort to encourage Medicaid members utilizing the ED for upper respiratory tract infections to use their health plan's 24-hour Nurse Advice Line. This initiative also educated members about the importance of establishing a relationship with a primary care provider for care needs.

Successes include:

- Promoted meaningful alternatives to emergency department visits that are consistent with the concept of the "medical home," an approach that delivers comprehensive primary health care and involves the patient, the provider and the family members.
- Use of an integrated care team approach to facilitate shared patient information and treatment plans for high-needs patients with frequent ED use, resulting in improved coordination of care, increased patient participation in creating the treatment plan, and better health outcomes and care utilization behaviors.
- All IMPROVE integrated care teams achieved promising post-intervention outcomes that included reduction in ED utilization and hospitalization for almost all of the targeted patients.

Evaluate the Ohio Administrative Requirements for MCPs to identify duplicative activities found in the NCQA standards, the BBA standards, and the Ohio requirements. HSAG will work with ODJFS and the MCPs to determine if MCPs may be eligible for exemption from a review of certain administrative functions when the accrediting organization's standards are comparable to ODJFS' requirements and survey periods.

Performs On-site Reviews of Call Centers to determine compliance with current American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (URAC) standards required by ODJFS.

Ohio

Pharmacy Program Reviews: HSAG conducts quarterly reviews of the structure of the MCPs pharmacy program submissions and provide ODJFS with the findings in an MCP-specific finding report; and review and make recommendations to ODJFS regarding pharmacy program policy and the MCP pharmacy program submission review process.

Validation of Managed Care Provider Network (MCPN) Submissions: HSAG conducts a quarterly audit of the provider panel information submitted by the MCPs to verify accuracy of the data, which will ensure that the MCPs are meeting provider capacity requirements (i.e. access standards). In addition, these audits validate the accuracy of the provider listings in the provider directory.

Evaluates the State Hearing Tracking Database for hearing notices the MCPs send to their members when the MCP denies a request for services or reduces, suspends or terminates a previously authorized service. The database tracks the specific time periods established for sending the hearing notices and monitors state requirements concerning state hearing notices.

Developed a Public Inquiries Tracking Database to track all managed care-related public inquiries received by ODJFS. The database supports data input and retrieval from multiple operational units at the state.

Develops MCP Performance Reporting to support the state's monitoring and oversight of the MCPs. The performance reporting systems includes a county-based and statewide approach for the CFC Program and a statewide approach for the ABD program. HSAG identifies a potential list of performance indicators for the states' consideration, compares rates to national benchmarks, identifies quality improvement opportunities, and recommends strategies for improving the performance rating system.

Most recently HSAG produces a **quarterly Medicaid newsletter** that is used to report the status of managed care plan performance in compliance with the performance goals of the State's quality strategy and initiatives to legislators, stakeholders and consumers. In addition, HSAG produces an **Annual MCP Performance Report** to report the annual performance of the MCPs compared to national and state benchmarks. This intended audience for this report are legislators, stakeholders and consumers.

Develops a Managed Care Plan Performance Dashboard to assist the state in monitoring key performance indicators for the MCPs. HSAG creates the programs, maintains and updates the dashboard data, and provides the software and hardware to support the project.

Conducts a Review of Abortion, Hysterectomy, and Sterilization Consent Forms to ensure completion as required by federal statutes. Encounter data is used to determine members whose claims/encounters are coded with one of the three procedures, and medical records are abstracted to ensure compliance with completion of the required forms.

Conducts Consumer-Focused Case Studies for the CFC and ABD populations to provide information about program orientation and service delivery.

Conducts Quality of Life Studies for the ABD population to obtain information concerning health-related quality of life experiences relevant to consumers who are aged, blind, and/or have

Ohio

chronic or disabling health conditions.

Prepares an Annual EQR Technical Report summarizing all EQR activities during the year and showing national benchmarks and plan comparisons for the scored activities.

Provides ongoing Presentations and Technical Assistance to ODJFS, stakeholders, and MCPs regarding:

- Feedback on Performance Measures
  - Covered Families and Children Managed Care Program
  - Aged, Blind, Disabled (ABD) Managed Care Program
- Nurse Practitioner Regulations
- Evaluating Quality of Care and Access to Services for Medicaid Managed Care Members
- Performance Improvement Projects
- Consumer-Focused Case Studies
- Quality of Life Studies
- Pay for Performance
- Coordination of Care
- Various other Topics Requested by ODJFS

Tennessee

Name of Agency:	**State of Tennessee** **Bureau of TennCare**
Contact Person:	John Couzins, MPH, CHCA EQRO Director QSource 49 Music Square West, Suite 402 Nashville, TN 37203 Telephone: 615.244.2007 E-mail: jcouzins@QSource.org
Duration of Project:	10/1/05-9/30/13 (Previous EQRO Contract 10/1/00 – 9/30/05)
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

The Bureau of TennCare has contracted with QSource, a federally recognized QIO, to provide independent external quality review (EQR) services for the Medicaid managed care companies (MCCs). QSource has sub-contracted with HSAG to provide the following services:

Conducts an On-Site Evaluation of Provider Network Adequacy to ensure that the MCCs have the capacity to provide covered services and that those services are accessible to enrollees. HSAG evaluates compliance with contract standards for network composition, geographic location, and access and availability. In addition, HSAG validates the MCCs credentialing and

Tennessee

recredentialing activities.

Validates Performance Measures to evaluate the accuracy of TennCare performance measures reported by the MCCs. As part of this task, HSAG reviews the data management processes of the MCCs, evaluates the algorithmic compliance, and verifies that the TennCare specified performance measures are based on accurate source information. HSAG includes the results of the performance measure validation process in the EQR Technical Report.

Under the previous external quality review organization (EQRO) contract, HSAG provided the State of Tennessee Department of Finance and Administration with an independent, external review of the quality of services available to the enrollees of the State's TennCare Program.

Contract requirements for the Tennessee EQRO project included:

Validated Performance Measures to evaluate the accuracy of TennCare performance measures reported by the MCCs. As part of this task, HSAG reviewed the data management processes of the MCCs, evaluated the algorithmic compliance, and verified that the State-specified performance measures were based on accurate source information. The results of the performance measure validation process were included in the EQR Technical Report.

Conducted an annual review of each MCC's Quality Improvement and Utilization Management Program Descriptions, associated work plans, and annual evaluations to determine if the program encompasses activities required to meet contract compliance and compliance with current industry, federal, and State requirements for Medicaid managed care programs. (This service was performed one time only.)

Validated one Performance Improvement Project (PIP) for each of the MCCs using CMS protocols and produced a written report of findings and recommendations. HSAG evaluated the soundness and results of the PIPs implemented by the MCCs. HSAG included the PIP validation results in the EQR Technical Report.

Prepared a detailed EQR Technical Report, describing the manner in which the data from all oversight activities, in accordance with 42 CFR 438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by TennCare-contracted MCCs. The report included objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

Conducted an annual On-Site Quality Survey of each MCC for contractual compliance. Review criteria included contract compliance to meet current industry, federal, and State requirements for managed care. HSAG provided a year-end written report with recommendations for each MCC program, as well as an aggregate report.

Conducted an On-Site Evaluation of Provider Network Adequacy to ensure that the MCCs had the capacity to provide covered services and that those services were accessible to enrollees. HSAG evaluated compliance with contract standards for network composition, geographic location, and availability.

Performed an On-Site Quality Survey for Monitoring Compliance with the EPSDT

Tennessee

Consent Decree. This review included two key components for explicit monitoring of compliance with EPSDT screening standards: (1) medical record review, and (2) monitoring and tracking of EPSDT services. The health plans were required to achieve and maintain the capability of tracking each child for the purposes of monitoring the child's receipt of the required screening, diagnosis, and treatment. The tracking system had the capacity to generate an immediate report on each child's EPSDT status.

Provided periodic management of special reviews and studies, such as encounter data validation (EDV), EPSDT services, disease-specific reviews and analyses, and any study that needed to be tailored for specific MCO issues. HSAG performed an EDV analysis of TennCare's Medicaid encounter to measure the accuracy, timeliness, completeness, and consistency of data encounters submitted to TennCare by the MCCs.

Provided special ad hoc reports, including an annual report of EPSDT findings. Reports also included recommendations that would improve the financial stability of the TennCare program and quality of care rendered to the TennCare population.

Provided a Quarterly Health Policy Report to keep the TennCare informed of national and state issues and standards for Medicaid managed care populations, Section 1115 Waivers, changes in BBAs, etc.

Developed an operational readiness methodology and related tools to conduct the readiness review for the management of TennCare's dental benefits by the newly selected contractor. HSAG evaluated operational readiness of the dental benefits manager to provide a provider network adequate to meet the TennCare's requirements for delivery of dental benefits.

Conducted an Independent Assessment of the State's 1915(b) Dual Eligible Waiver.

Vermont	
Name of Agency:	**Vermont Agency of Human Services (AHS)**
Primary Contact Person:	Shawn Skaflestad, PhD Quality Improvement Manager Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203 Telephone: 802.241.1160 E-mail: Shawn.Skaflestad@ahs.state.vt.us
Duration of Project:	11/15/07 – 11/14/11
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

As the contracted external quality review organization (EQRO) for the Vermont Agency of Human Services (AHS), HSAG's external quality review (EQR) activities focus on the MCO programs operated by the statewide MCO, the Department of Vermont Health Access (DVHA), formerly the Office of Vermont Health Access (OVHA), through its inter-governmental agreements with AHS Departments/Divisions and a network of community-based providers. The scope of work includes the three mandatory activities:

- Validation of AHS-required performance improvement projects.
- Validation of AHS-required performance measures.
- Review of MCO compliance with federal and AHS-specified standards for quality program operations.

In addition, HSAG prepares an annual EQR technical report and provides technical assistance and guidance to the AHS and/or the DVHA quality improvement and operations staff to support their goals and activities in providing timely, accessible, and quality services to beneficiaries.

Validation of Performance Improvement Projects (PIPs) involves HSAG annually validating the DVHA's PIP(s). As part of its validation activities, HSAG evaluates the measurement of specific outcome indicators. HSAG prepares and submits to AHS and DVHA an annual PIP validation report of its validation activities and DVHA's PIP performance results.

Validation of Performance Measures designated by the AHS. HSAG's validation of DVHA's performance measures includes:

- Evaluating the accuracy of performance measures reported by, or on behalf of, the MCO.
- Determining the extent to which the performance measures calculated by the DVHA (or entity acting on behalf of the MCO) followed specifications established by the State for the calculation of performance measures.

HSAG validates data reported by the DVHA and assists AHS by preparing measure specifications and the data submission tool used by the MCO to meet each year's data collection requirements. HSAG prepares a Validation of Performance Measures Report upon completion of this annual activity.

Vermont

Review of Compliance with Standards involves HSAG's evaluation of the DVHA's performance with respect to its compliance with the federal Medicaid managed care and AHS-specified IGA (contract) requirements and standards. HSAG conducts both a desk review of the DVHA's documentation and an on-site review of additional documents and interviews with key DVHA management and program staff members. HSAG prepares a narrative summary report of reviewer findings that includes a presentation and analysis of the findings and performance data/scores, a summary of the DVHA's strengths and opportunities for improvement, and recommendations to improve its performance related to the quality and timeliness of, and the access to, care and services provided by the MCO.

Preparation of an EQR Technical Report, includes describing the manner in which, in accordance with 42 CFR 438.358, HSAG aggregated and analyzed the data from all EQR activities and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO operated by the DVHA. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

The technical report also includes an assessment of the MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries; recommendations for improving performance related to these same aspects of health care services; and an assessment of the degree to which the DVHA has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's review processes.

Washington	
Name of Agency:	**Department of Social and Health Services** **Medical Assistance Administration**
Contact Person:	Michael Cooper, RN, MN Director, State and Private Services Acumentra Health 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201-4960 Telephone: 503.382.3929 E-mail: mcooper@acumentra.org
Duration of Project:	2/8/02–12/31/11
Cost of Project:	[redacted]

Description of Services Performed and Deliverables:

As a subcontractor to Acumentra, the Washington EQRO, HSAG conducts CAHPS Surveys and the Validation of Performance Measures for the Medical Assistance Administration (MAA), Department of Social and Health Services (DSHS) in Washington State.

Contract requirements include:

Administers CAHPS Surveys to the state's FFS and SCHIP populations on a biannual basis. HSAG also performs data analysis and reporting of FFS, SCHIP, and Washington Medicaid Integration Partnership (WMIP) CAHPS data.

In previous contract years, HSAG was responsible for the Validation of Performance Measures identified by MAA for each MCO. HSAG conducted HEDIS Compliance Audits to evaluate the accuracy of Medicaid performance measures reported by each MCO and determined the extent to which Medicaid-specific measures calculated met the NCQA HEDIS specifications.

HSAG's Experience as a QIO

The following tables provide supporting documentation for HSAG's experience as a QIO as well as additional special studies performed for CMS as part of the larger scopes of work.

Federal – Medicare	
Name of Agency:	**Centers for Medicare & Medicaid Services (CMS)**
Primary Contact Person:	Naomi Haney-Ceresa Contracting Officer Office of Acquisition & Grants Management Centers for Medicare & Medicaid Services (CMS) 7500 Security Boulevard, MS C2-21-15 Baltimore, MD 21244 Telephone: 410.786.1607 E-mail: Naomi.haney-ceresa@cms.hhs.gov
Duration of Project:	8/1/11–7/31/14 Previous: 1979–2011
Cost of Project:	[redacted]
Description of Services Performed:	

HSAG has served as the QIO for the state of Arizona since 1979, and has participated in all 10 Scopes of Work.

For the 10th Scope of Work, HSAG efforts are focused on three aims: better patient care, better population health, and lower healthcare costs through improvement. HSAG works with patients, providers, and practitioners across organizational, cultural, and geographic boundaries to spread rapid, large-scale change. The work that spans every setting in which healthcare is delivered, including the critical transitions between those settings.

HSAG is helping local communities meet national goals in four primary areas: Improve Individual Patient Care, Improve Health for Populations and Communities, Integrate Care for Populations and Communities, and Deliver Beneficiary and Family-Centered Care.

Improve Individual Patient Care

HSAG's QIO patient safety initiatives in hospitals will reduce central-line bloodstream infections (CLABSIs) by implementing the Comprehensive Unit-based Safety Program (CUSP), then expand to encompass catheter-associated urinary tract infections (CAUTIs), Clostridium difficile infections, and surgical site infections. Hospitals that join in the QIO Program's healthcare-associated infection (HAI) initiatives will contribute to as much as a 50 percent reduction in national HAI rates.

HSAG provides technical assistance to all Medicare-participating hospitals for reporting inpatient and outpatient quality data to CMS. Accurate data about hospital quality means more transparency about the state of quality and safety at Arizona's hospitals. The clinical data HSAG guides Arizona hospitals in collecting are the same data CMS uses to populate the *Hospital Compare* Web site, which is designed to help consumers decide where to receive care. They are

Federal – Medicare

also the same data CMS will use to calculate value-based payment rates.

Improve Health for Populations and Communities

HSAG is assisting physician practices that want to use their electronic health record system to coordinate preventive services and report related quality measures to CMS. Practices can also participate in a learning network focused on reducing patient risk factors for cardiac disease. HSAG partners with the local Health Information Technology Regional Extension Center (REC) to promote health IT into clinical practice.

Integrate Care for Populations and Communities

HSAG is working to bring together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions. Goals are to build capacity for improving care transitions and to support the coalition's success in obtaining grant funding through Section 3026 of the Affordable Care Act.

Beneficiary and Family-Centered Care

HSAG is responsible for protecting the rights of Medicare beneficiaries by carrying out statutorily mandated review activities that include:

- Reviewing the quality of care provided to beneficiaries.
- Reviewing beneficiary appeals of certain provider practices.
- Reviewing hospital emergency rooms' adequate first response in a medical crisis.
- Implementing quality improvement activities as a result of case review.

HSAG uses all data related to case review activities to identify problems related to quality of care and designs quality improvement activities aimed at providers (including hospitals, nursing homes, etc.) and individual healthcare practitioners.

Learning and Action Networks

To assist in achieving quality improvement across all aims, HSAG is working to establish learning and action networks (LANs) to bring a community together with many different stakeholders, advocates, and patients/families. With HSAG's guidance, LAN members will gather to learn and explore ways to solve complex community problems. First, LAN members will learn from existing statewide experiences and actions. Then they will create and implement unique solutions in their communities. LAN members will promote patient and family participation in actions to improve health, analyze health outcomes at a community level to identify best practices, and rapidly spread those best practices statewide. Currently, there are six LANs: Care Transitions, HAIs, HACs, ADEs, Prevention, and Cardiac Health.

Federal – Measures Management System

Name of Agency:	**CMS**
Primary Contact Person:	Edward Garcia Health Policy Analyst Quality Measurement and Health Assessment Group Centers for Medicare & Medicaid Services 7500 Security Blvd., Baltimore, Maryland 21244-1850 Telephone: 410.786.6738 E-mail: edward.garcia@cms.hhs.gov
Duration of Project:	8/1/11–7/31/14
Cost of Project:	[redacted]

Description of Services Performed:

Measures Management System

♦ HSAG contracts with the Centers for Medicare & Medicaid Services (CMS)—specifically the Quality Measurement and Health Assessment Group (QMHAG) within CMS' Office of Clinical Standards and Quality—to implement the CMS Measures Management Special Project. CMS launched the Special Project in October 2003 to implement a more standardized and efficient management system for the development and maintenance of quality measures. This is known as the CMS Measures Management System and is documented in the "*Blueprint*." QMHAG initiated the CMS Measures Management Special Project because of increasing demand from a wide variety of stakeholders for valid, reliable quality measures that can determine whether high-quality care is being provided consistently across the health care delivery system. While quality measurement is a critical tool for improving quality and supplying information to consumers and purchasers in a market-driven health system, the field is still evolving and growing rapidly. The CMS Measures Management Special Project is expected to assist QMHAG in meeting a diversity of policy and program needs.

Project Objectives

The primary tasks of the project are to:

- Provide support in developing long-range plans for measure development, endorsement, and maintenance activities by conducting measure gap analyses and focused environmental scans.
- Provide support and analysis for measure harmonization and simplification.
- Provide support for implementation of various Affordable Care Act (ACA) programs with regard to measure selection.
- Monitor and participate in innovative issues in quality measurement, such as the development of quality measures from electronic health records.
- Provide technical assistance to CMS measure development contractors regarding the MMS Blueprint.
- Collaborate with the National Quality Forum, the American Medical Association (AMA)-

Federal – Measures Management System

Physician Consortium for Performance Improvement, The Joint Commission, the Agency for Healthcare Research and Quality, and other major measure developers in developing quality measurement policies and methodology.

- Provide educational sessions to QMHAG staff and management regarding the Measures Management System Blueprint and new developments in the quality measure environment.

Progress

HSAG has implemented both the Measures Management System (MMS) and the CMS Measure Inventory which includes all current and identified future CMS measures. HSAG also produces a monthly Journal Scan, which focuses on quality measures used in CMS programs. HSAG is assisting CMS internal team in the planning and implementation of various quality initiations, including supporting the monthly CMS Measures Forums, Interagency Quality Measurement Work Group meetings, collaborating with NQF and CMS, and providing monthly CMS Informational sessions on the MMS Blueprint.

Current Status

- CMS has deployed MMS in most of its health care quality measure development and maintenance activities.
- HSAG is assisting CMS in the development and implementation of policies and procedures for aligning, simplifying and harmonizing measures across programs and initiatives.
- HSAG is working on enhancing the MMS based on users' feedback as well as incorporating features pertaining to new CMS quality initiatives.
- HSAG is working with QMHAG to develop its five year strategic plan regarding measurement activities.
- HSAG is working with various measure developers and CMS to post calls for Technical Expert Panels and calls for public comments on measures.
- HSAG is working with CMS on redesigning the CMS Medicare "Quality Initiatives" web pages.

Federal – CAHPS® Hospital Survey (HCAHPS)	
Name of Agency:	**CMS**
Primary Contact Person:	Elizabeth Goldstein, PhD Director, Division of Consumer Assessment and Plan Performance Centers for Medicare & Medicaid Services 7500 Security Blvd S1-13-05 Baltimore, Maryland 21224-1850 Telephone: 410.786.6665 E-mail: egoldstein@cms.hhs.gov
Duration of Project:	9/30/03–7/31/12
Cost of Project:	[redacted]

Description of Services Performed:

HSAG has played a major role in the implementation of the CAHPS® Hospital Survey (herein after referred to as the HCAHPS Survey) since 2003. This standardized survey instrument is being utilized to collect and report information on hospital patients' perspectives on the care they receive. The HCAHPS project is part of a larger voluntary reporting effort that is being coordinated by the *Quality Initiative: A Public Resource on Hospital Performance*, and includes key organizations and stakeholders with an interest in reporting on hospital quality. It is CMS' ultimate goal that the publicly reported HCAHPS data are sufficiently valid and reliable to permit accurate comparisons of patient perspectives across hospitals. This is being accomplished by a carefully coordinated effort at the national level, encompassing multiple independent survey vendors and hospitals, using a standardized instrument and protocols.

In support of the HCAHPS initiative, HSAG has been responsible for conducting a broad array of tasks, including the following:

- Provide project management and oversight across multiple tasks and partners
- Conduct national training for those hospitals and survey vendors participating in the ongoing HCAHPS data collection, and develop technical assistance and training materials
- Develop Quality Assurance Guidelines
- Manage the HCAHPS data collection and submission processes
- Conduct monitoring and oversight activities, including on-site visits, teleconferences, and review of Quality Assurance Plans
- Validate the integrity of HCAHPS data collected by participating hospitals and survey vendors
- Analyze the HCAHPS data and generate summary file extracts for purposes of public reporting on the Hospital Compare web site
- Develop and maintain a project web site, www.hcahpsonline.org
- Provide technical assistance and information support
- Conduct Mode Experiments comparing modes of survey administration and conduct analyses that establish adjustments for patient-mix and nonresponse

Federal – CAHPS® Hospital Survey (HCAHPS)

- Facilitated the development and leadership of a Technical Expert Panel

HSAG routinely analyzes and reports the data on a quarterly basis for approximately 4,000 hospitals participating in HCAHPS public reporting. HCAHPS results are publicly reported on the Hospital Compare Web site. HSAG continues to enhance the HCAHPS Quality Assurance Guidelines, which are currently in their fifth edition. The use of HCAHPS data has been linked to pay for reporting of acute care hospitals.

Federal – Medicare Advantage & Prescription Drug Plan CAHPS® Survey

Name of Agency:	**RAND Corporation/CMS**
Primary Contact Person:	Marc Elliott, PhD Senior Statistician RAND Corporation Telephone: 310.393.0411, ext. 7931
Duration of Project:	9/30/09–9/29/14
Cost of Project:	[redacted]

Description of Services Performed:

In September 2009, the Centers for Medicare & Medicaid Services (CMS) awarded a contract to the RAND Corporation, with a subcontract to HSAG, to implement the Medicare Advantage & Prescription Drug Plan (MA & PDP) CAHPS® Survey. The MA & PDP CAHPS® Survey employs self-reported sets of questionnaires designed to assess the experiences of Medicare enrollees in Medicare Advantage (MA) and Prescription Drug (PD) plans. Traditionally, CMS has paid for all data collection activities and has contracted with a single contractor for data collection. Under this contract, RAND Corporation and HSAG have collaborated in the development and preparation of project materials and infrastructure to move the MA & PDP CAHPS® Survey from a single contractor data collection model to a model in which multiple survey vendors conduct the survey on behalf of MA and PD contracts. Beginning in 2011, CMS is requiring all MA and PD contracts with enrollees of 600 or more to contract with approved survey vendors to collect and report CAHPS® survey data following the protocols established by CMS.

Under this subcontract award, HSAG is responsible for the performance of several key tasks, including the development and implementation of the Quality Assurance Protocols and Technical Specifications manual (versions 2.0, 3.0 and 4.0), the MA & PDP CAHPS® Survey project web site (www.ma-pdpcahps.org), the information and technical assistance support telephone line and electronic mailbox, monitoring and oversight activities, and national training.

Federal – Medicare Health Outcomes Survey (HOS)	
Name of Agency:	**CMS**
Primary Contact Person:	S. Chris Haffer, PhD Director, Medicare Health Outcomes Survey Centers for Medicare & Medicaid Services 7500 Security Blvd., MS C3-18-24 Baltimore, Maryland 21244-1850 Telephone: 410.786.8764 E-mail: chris.haffer@cms.hhs.gov
Duration of Project:	5/98–5/16
Cost of Project:	[redacted]

Description of Services Performed:

HSAG has played an integral role in the Medicare Health Outcomes Survey (HOS) project since its national implementation in 1998. HSAG has been CMS' data analysis, dissemination, education, and applied research contractor for the Medicare HOS program since 1998. Key tasks in HSAG's Scope(s) of Work continue to include annual data cleaning, analysis and dissemination; education and outreach; maintenance of the HOS Web site (www.hosonline.org); technical program support and assistance; and ad hoc analyses.

The Medicare HOS is a longitudinal evaluation of the physical and mental health outcomes of beneficiaries enrolled in Medicare managed care plans nationwide, and is the first outcomes measure used in Medicare managed care. The HOS measure has been included in the Health Plan Employer Data and Information Set (HEDIS®) performance measures sponsored by the National Committee for Quality Assurance (NCQA) since 1998. The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. All managed care plans with Medicare Advantage (MA) contracts must participate.

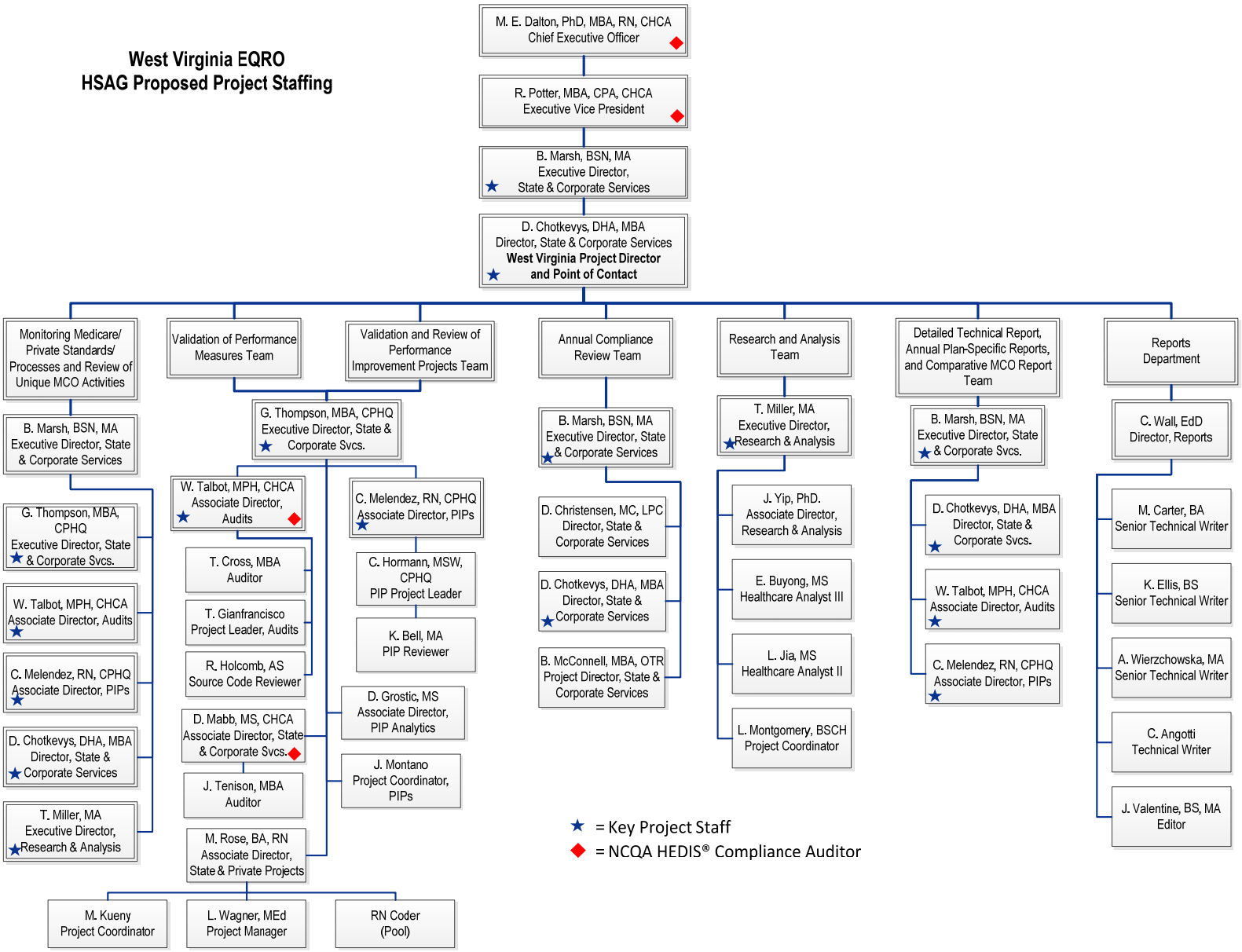
A few selected examples of key tasks that illustrate HSAG's accomplishments over the years in support of the HOS Program include the following items. In 2002, the HOS-Modified (HOS-M) was fielded, targeting Medicare beneficiaries at greatest risk for poor health outcomes. With the implementation of HOS-M, all data analyses and report activities for both surveys (HOS and HOS-M) have been conducted in parallel. A pilot project to demonstrate the use of the HOS results to manage depression in primary care settings was completed in the fall of 2002. In 2003, HSAG developed the CMS HOS Web site, which it continues to maintain. The journal Health Care Financing Review devoted its entire summer 2004 edition to research based on HOS data. A preliminary study of the feasibility of integrating the HOS with the Medicare+Choice CAHPS® survey was completed in 2005. In 2006, HOS 2.0 was implemented, and HSAG applied conversion formulas that allowed the reliable comparison of HOS 1.0 and HOS 2.0 results in MA Plan and QIO reports. In 2009, CMS and the National Cancer Institute (NCI) executed an Inter-Agency Agreement, which added tasks to HSAG's SOW, including the development of the Surveillance, Epidemiology and End Results – Medicare HOS (SEER-MHOS) linked database web site, as well as technical assistance and

Federal – Medicare Health Outcomes Survey (HOS)

support for health care researchers. Numerous reports, manuscripts, and presentations have been produced on specific HOS research topics.

Since 1998, more than 4.7 million Medicare beneficiaries have been surveyed, and HSAG has analyzed and reported the data on more than 2.6 million beneficiaries.

West Virginia EQRO
HSAG Proposed Project Staffing



Mary Ellen Dalton, PhD, MBA, RN, CHCA
Chief Executive Officer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016
602.801.6701
mdalton@hsag.com

Qualification Highlights

Dr. Dalton has over 30 years of health care industry experience, in Medicare, Medicaid, and the private sector. She has more than 30 years of quality improvement organization (QIO) experience specifically, beginning her employment at the Professional Services Review Organization (PSRO) in 1979, performing supervisory functions for case review. In 1983, she expanded peer review activities to employer groups and purchasers. She has held senior management positions in all facets of QIO work, including special studies. In 1997, Dr. Dalton expanded HSAG into Medicaid with External Quality Review Organization (EQRO) contracts. From 2000 until 2007, she was the Executive Vice President, with oversight responsibility for the successful completion of task deliverables, budgeting, staffing, and contracting. Since 2007, she has held the position of Chief Executive Officer.

Dr. Dalton serves on the HSAG Board of Directors and is a member of the Executive Management Team. Dr. Dalton is an NCQA-Certified HEDIS® Compliance Auditor, as well as a Diplomate with the American Board of Quality Assurance and Utilization Review Physicians.

In April 2010, Dr. Dalton joined the board of the Arizona Health-e Connection.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Chief Executive Officer: Dr. Dalton provides guidance to the Board of Directors in developing its strategic vision for HSAG and provides leadership and direction for all activities of the organization. She also lends expertise in the areas of External Quality Review.

NCQA-Certified HEDIS® Compliance Auditor: Conducts thorough audits of Medicaid, Medicare, and Commercial Health Plans to ensure that data collection and reporting procedures are in compliance with HEDIS® specifications and are comparable to reported rates from other Health Plans. This includes a thorough review of health plan's information systems, claims processing, membership, and provider data.

Northern Arizona Medical Evaluation System (NAMES)/ Health Services Advisory Group, Inc. (HSAG), Associate Director: Responsible for providing direction and leadership to all managers within the organization that included review, quality assurance, and data. Coordinated and developed methods to implement Medicare review in all Northern Arizona hospitals. Review Manager: Responsible for managing and providing direction and support to senior review coordinator for quality assurance and utilization review activities.

Comprecare, Inc., Quality Assurance-Utilization Review Supervisor: Designed, organized, and managed the quality assurance and utilization review program for the fastest growing HMO-IPA in the country. Implemented all inpatient monitoring activities in hospitals in the Denver metropolitan area. Coordinated the activities of regional physician peer review group meetings. Responsible for monitoring Comprecare compliance with all applicable federal, state, and local standards and regulations.

Previous Experience

Health Services Advisory Group, Inc. (HSAG), Phoenix, Arizona, Executive Vice President; NCQA-Certified HEDIS® Compliance Auditor; Vice President, State and Corporate Services; Contract Manager, EQRO (Arizona, California, Nevada, and Tennessee); Project Administrator, Research & Development; Associate Director, Professional Relations; Professional Services Consultant; Director, Marketing & Professional Relations; 1984–Present

Northern Arizona Medical Evaluation System (NAMES)/Health Services Advisory Group, Inc., Phoenix, Arizona, Associate Director; Review Manager; Senior Review Coordinator; 1979–1984

Comprecare, Inc., Denver, Colorado, Quality Assurance-Utilization Review Supervisor; 1978–1979

Drs. Arthur and Blakeman, Denver, Colorado, Office Manager; 1976–1978

Colorado Foundation for Medical Care, Denver, Colorado, PSRO Program Coordinator; 1974–1976

Denver General Hospital, Denver, Colorado, Staff Nurse and Relief Charge Nurse; 1971–1974

New York Hospital – Cornell Medical Center, New York, New York, Staff Nurse; 1970–1971

Education

PhD, with emphasis in Public Administration, Arizona State University, Tempe, Arizona, 2008

MBA, Executive Program, Arizona State University, Tempe, 1999

Bachelor of Science, Allied Health-Specialty Nursing, Colorado Women's College, Denver, Colorado, 1977

Diploma in Nursing, Helene Fuld School of Nursing, Trenton, New Jersey, 1970 (Received full scholarship for entire nursing training)

Certifications, Professional Organizations, and Publications

Professional Organizations

Member, Board of Directors, HSAG, 8/82–Present

Member, Board of Directors, Florida Medical Quality Assurance, Inc. (FMQAI), 7/03–Present

Member, Board of Directors, American Health Quality Association (AHQA), 2/07–Present

Member, Board of Directors, Phoenix Healthcare Value Measurement Initiative

Member, Board of Directors, Arizona Health-e Connection

Member, Women Business Leaders of the U.S. Health Care Industry Foundation

Member, Expert Panel CMS National Review Protocol Contract

Member, Insurance Committee for the Governor's Council for Spinal Head Injuries, 1995–Present

Member, Arizona Partnership for Infant Immunization, 1994–Present

Member, Executive MBA Program Advisory Panel

Member, NCQA Audit Methodology Panel

Member, Women in Healthcare – 3/01

Member, Using EQROs to Enhance Quality of Services for Young Children in Medicaid: Recommended Strategies for State Medicaid Agencies, 2003

Pi Alpha Alpha, National Honor Society for Public Affairs and Administration, Arizona State University Chapter, 4/04

Certifications

Certified HEDIS® Compliance Auditor (CHCA), NCQA, 11/98–Present

Diplomate, American Board of Utilization Review & Quality Assurance Physicians (ABQAURP), 11/96–Present

Arizona State University

The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Mary Ellen Dalton

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Doctor of Philosophy
Public Administration
in the
College of Public Programs

with all the Rights, Privileges and Honors thereunto appertaining
this eighth day of May, two thousand and eight.

Jan Napolitano
Governor of Arizona

Fred E. Boice
President of the Board

ARIZONA STATE UNIVERSITY · 1885 · GREAT SEAL OF THE STATE OF ARIZONA · 1912 ·

Michael Crow
President of the University

(CUT HERE)

ARIZONA STATE BOARD OF NURSING
4747 N. Seventh Street, Suite 200
Phoenix, AZ 85014-3655
(602) 889-5150

RN RENEWAL

License issued to

DALTON, MARY ELLEN
[redacted]

Signature:

RENEWAL DUE DATE	LICENSE NO.
04/01/2014	[redacted]

(CUT HERE)

(CUT HERE)

KEEP THE BOARD INFORMED

www.azbn.gov

IMPORTANT INFORMATION

Practicing nursing without a current license is unlawful. To avoid late fees or other penalties, renew online prior to the renewal date printed on the front of your license.

ADDRESS CHANGE: Go to www.azbn.gov/myservices, click on login retrieval form for user name and pin number, continue as directed.

NAME CHANGE: You must provide the Board with a copy of the documentation evidencing that your name has changed (i.e. marriage license, divorce decree, driver's license, social security card). If you are requesting a new license reflecting the name change, you are required to send your current license along with the documents showing your name has changed. To find the current fee, go to web page, resources, and then agency fee structure.

LOST/STOLEN LICENSE: Notify this office within 5 working days, (602) 889-5150.

MULTI STATE LICENSURE: To determine which states are compact states, contact www.ncsbn.org.

Phone: (602) 889-5150 **Fax:** (602) 889-5155
E-mail: arizona@azbn.gov **Website:** www.azbn.gov

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

Mary Ellen Dalton

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2010
DATE CERTIFIED

10/31/2012
EXPIRATION DATE

Richard G. Potter, MBA, CPA, CHCA
Executive Vice President and Chief Operating Officer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6702

rpotter@hsag.comrpotter@hsag.com

Qualification Highlights

Mr. Potter has extensive experience in, and knowledge of, health care quality systems and managed care programs as they relate to performance based contracting, and in SCHIP reimbursement systems. As Executive Vice President, HSAG, and Chief Executive Officer, HSAG of CA, he oversees the development and implementation of the strategic operational plan to achieve quality improvement goals established by the Centers for Medicare and Medicaid Services (CMS) on the CMS Medicare Statement of Work contracts for Quality Improvement Organizations (QIO.)
As Deputy Director, Arizona Health Care Cost Containment System (AHCCCS), 1996 to 1998, he successfully designed, planned, and implemented Arizona's Children's Health Insurance Program, "KidsCare," and worked with Arizona State Legislators to successfully gain consensus on a defined benefit package, eligibility criteria and a member enrollment process for a $60 million state premium sharing program that provides health insurance to uninsured working individuals and their families. From 1990 to 1996, Mr. Potter was responsible for financial and operational oversight of the AHCCCS acute care health plans, long-term care program contractors and Regional Behavioral Health Authorities.
As a Principal with William M. Mercer, Inc., he managed projects to establish risk-adjusted rates, operational and financial health plan reviews, quality assurance programs, develop capitation rates, and conduct health plan rate negotiations.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group of California, Inc. (HSAG-CA), Chief Executive Officer: Oversight responsibility for the California CMS Quality Improvement Organization activities, including all tasks and deliverables.

Health Services Advisory Group, Inc. (HSAG), Executive Vice President: Mr. Potter is responsible for oversight and management of all divisions at HSAG: Federal, State & Corporate, and Surveys, Research & Analysis. He is responsible for overall organizational performance and staff development. Mr. Potter has final approval on all reports, deliverables, and contract issues. He leads the

organization in the CEO's absence, and represents the organization in the community in a leadership capacity.

Vice President, Operations: Formerly, as Vice President, Operations, Mr. Potter's responsibilities included oversight of all state Medicaid external quality review contracts, including ultimate oversight for all contract deliverables and work performed. In addition, he provided contract transition and coordination of implementation processes on new EQRO contracts. Mr. Potter is an NCQA-Certified HEDIS® Compliance Auditor and has participated on numerous audits.

William M. Mercer, Incorporated, Principal: As a client leader, responsible for overall management of the services that Mercer provided in five states including coordinating specific Mercer projects to ensure they are completed on time and within budget. Recent projects included establishing risk-adjusted rates, conducting operational and financial health plan reviews, creating quality assurance programs, developing capitation rates, and completing health plan rate negotiations. In addition, Mr. Potter assisted in the completion of a strategic plan for the Nevada Legislature and the Nevada Department of Human Resources on ways to improve delivery of health care services in rural areas of the State. Areas of expertise include the design, development, and implementation of managed care delivery systems.

Arizona Health Care Cost Containment System (AHCCCS), Office of the Director, Deputy Director: Mr. Potter was responsible for directing day-to-day operations of the State Medicaid agency with an operating budget in excess of $2 billion and over 1,100 employees, and for strategic planning and implementation of major health care delivery programs. He successfully designed, planned, and implemented Arizona's Children's Health Insurance Program in November 1998; and in 1996 worked with state legislators to successfully gain consensus on a defined benefit package, eligibility criteria and a member enrollment process for a $60 million state premium sharing program that provides health insurance to uninsured working individuals and their families.

As **Assistant Director - Office of Managed Care**, Mr. Potter was responsible for directing a staff of approximately 30 employees in the areas of financial and operational oversight of AHCCCS acute care health plans, AHCCCS long-term care program contractors and Regional Behavioral Health Authorities; in the area of verifying eligibility determinations made by the Department of Economic

Security, counties and ALTCS, and a staff of approximately 15 employees in the administration of Health Care Group which provides health care benefits to small Arizona businesses. His specific responsibilities included:

- Administered the acute and long term health care contract procurement cycles including the development of the RFP document, evaluation criteria, and contract award recommendations that resulted in the annual awarding of over $1.5 billion in contracts to HMOs.
- Directed impact studies on possible federal and state legislation and other mandates.
- Developed operational/financial indicators to measure health plan performance.
- Developed policies/procedures that affected the delivery of health care services.
- Conducted monthly and quarterly meetings with the CEOs and Medical Directors of HMOs.

As **Financial Manager – Office of Managed Care**, Mr. Potter was responsible for financial oversight of $1.5 billion in contracts with HMOs. He directed CPAs in addressing all major issues relating to HMO financial activities, including analysis of HMO costs and compliance with all contractual requirements for acute and long-term care contracts. Mr. Potter participated in decisions related to capitation rate negotiations, procurement of HMOs, and approval of policies and procedures.

- Developed Financial Reporting Guide for AHCCCS HMOs.
- Developed FQHC cost reimbursement guidelines.
- Requested by HCFA to develop HMO solvency guidelines for use by states entering into Medicaid managed care programs.
- Selected by HCFA as chairman of the Medicaid Managed Care Technical Advisory Group that advises HCFA on significant Medicaid managed care issues.

Previous Experience

Health Services Advisory Group, Inc. (HSAG), Phoenix, Arizona, Executive Vice President, Vice President, Operations, 2003–Present

William M. Mercer, Incorporated, Phoenix, Arizona: Principal; 1998–2003

AHCCCS, Phoenix, Arizona: Deputy Director (10/96–12/98); Assistant Director – Office of Managed Care (1/93–9/96); Financial Manager - Office of Managed Care (10/90–12/92); 1990–1998

KPMG Peat Marwick, Los Angeles, California: Senior Audit Manager; 9/83–10/90

Education

MBA, Arizona State University, Tempe, Arizona, 2007

Bachelor of Science, Accounting, California State University at Northridge, Northridge, California 1981

Certifications, Professional Organizations, and Publications

Certified Public Accountant, American Institute of Certified Public Accountants

CMS Medicaid Managed Care Technical Advisory Group, Chairman (1996–1998)

Certified HEDIS® Compliance Auditor (CHCA), National Committee for Quality Assurance

Arizona State University
University Registrar's Office
P.O. Box 870312
School Code: 001081
Tempe, Arizona 85287-0312
(480) 965-3124

Enrollment Verification as of 2/28/2012

Name: Richard G Potter ID Nbr: [redacted]

Degrees Earned

Deg Date	Degree	Major
05/10/2007	MBA	W. P. Carey MBA

Enrollment History

Term	Career	Begin Date	End Date	Units	Status
2005 Fall	GRAD	08/22/2005	12/15/2005	11.00	Full-Time
2006 Spring	GRAD	01/16/2006	05/11/2006	13.00	Full-Time
2006 Fall	GRAD	08/21/2006	12/14/2006	12.00	Full-Time
2007 Spring	GRAD	01/15/2007	05/10/2007	14.00	Full-Time

Sincerely,

Louise Denny
University Registrar

Department of

Consumer Affairs

State Board of Accountancy

Under and by virtue of the provisions of an Act of the Legislature of the State of California creating a State Board of Accountancy

This Certificate is granted to

Richard Glenn Potter

to practice as a

Certified Public Accountant

Given under our hands and the Seal of the State Board of Accountancy

at Sacramento, California this twenty-third *day of* September 1983

Ira M. Landis
SECRETARY

Thomas Tino
PRESIDENT

EXECUTIVE OFFICER

Certificate Number [redacted]

OF CALIFORNIA
DEPARTMENT OF
nsumer
Affairs

11L-2 (REV. 5-82)
• OSP

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

Richard Potter

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2010	10/31/2012
DATE CERTIFIED	EXPIRATION DATE

Bonnie Marsh, MA, BSN, RN
Executive Director, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110
Honolulu, HI 96814
808.941.1444
bmarsh@hsag.com

Qualification Highlights

Ms. Marsh is a Registered Nurse with over 30 years of health care and behavioral health experience. She has provided professional leadership and management in both the public and private sectors, including the Arizona Health Care Cost Containment System, Arizona's Medicaid agency.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Executive Director, State & Corporate Services: Ms. Marsh oversees the development of all project deliverables. She is responsible for the quality of all work performed by project staff and for client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. Ms. Marsh develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's quality review program.

Arizona Health Care Cost Containment System (AHCCCS), Behavioral Health Manager: Responsible for ensuring implementation of Medicaid and SCHIP behavioral health program according to applicable federal and state regulations, and Arizona's 1115 waiver; monitoring delivery of behavioral health services by contracted MCOs and PIHPs, including structure and operations, quality of care, financial reporting, and adherence to contract standards; representing AHCCCS at multiple public and private entity task forces, committees and work groups, including CMS' Performance Measurement Partnership Project for development of standardized performance measures for states' Medicaid and SCHIP programs; developing, implementing and updating policies, administrative rules and programs related to delivery of behavioral health services; providing policy and rule interpretation and technical assistance; and supervising a staff of nine.

COMCARE (formerly CODAMA Services), Director of Nursing Services: Provided professional leadership for development and management of nursing services and professional staff; provided clinical supervision of 30+ psychiatric nurses; developed nursing job descriptions, policies/procedures, nursing sub-committees, and education and training requirements; participated as a member of management team, Risk Management Committee, Pharmacy and Therapeutics Committee, Medical Records Task Force, health plan coordination meetings, and Flinn Foundation Project Team.

Director of Member Services, Grievance and Appeals (1994): Developed and implemented grievance and appeal processes and member advocacy forums for clients and family members; directed risk management activities including incident and accident reporting, mortality review, and acted as legal liaison; developed department policies and procedures; provided direct supervision to four staff and indirectly supervised six staff.

Director of Quality Assurance and Utilization Management Services (1992-1994): Developed and directed organizational units responsible for QA and UR programs, risk management, grievance and appeals, member services, medical records, and legal coordination; monitored quality and appropriateness of direct services and contracted provider network; monitored and investigated client critical incidents, complaints and grievances; developed and implemented organizational policies, procedures and documentation standards; supervised 30+ staff.

Previous Experience

HSAG, Phoenix, Arizona: Executive Director, State & Corporate Services; 2004-Present

AHCCCS, Phoenix, Arizona: Behavioral Health Manager, 1996-2004

COMCARE, Phoenix, Arizona: Director of Nursing Services, 1992-1996

OptimumCare Corporation, Laguna Niguel, California: Director, Senior Mental Health Program, 1991-1992

Camelback Behavioral Health Services, West Valley Camelback Hospital, Glendale, Arizona: Director of Adult Services and Assistant Director of Nursing, 1982-1991

Scottsdale Camelback Hospital, Scottsdale, Arizona: Nurse Coordinator, 1982-1985

Arizona State Hospital, Phoenix, Arizona: Admissions Nurse (1980-1982); Evening Charge Nurse (1979-1980); 1979-1982

St. Luke's Hospital, Phoenix, Arizona: Intake Therapist (1978-1979); Staff Nurse (1976-1978); 1976-1979

St. Vincent Hospital, Toledo, Ohio: Staff Nurse, 1973-1976

Education

MA, Organizational Management, University of Phoenix, Phoenix, Arizona, 1991

BS, Nursing, University of Phoenix, Phoenix, Arizona, 1985

RN (Diploma Program), St. Vincent Hospital School of Nursing, Toledo, Ohio, 1973

Certifications, Professional Organizations, and Publications

Certifications:

Certification by the American Nurses Association as Psychiatric and Mental Health Nurse, 1984

Certification by the Arizona Board of Certification of Alcoholism Counselors, 1979

Professional Organizations/Appointed Board Memberships:

Harris Institute Advisory Board, 2004

Governor-appointed Member, Arizona State Hospital Advisory Board, 2000-2003, and elected Chairperson, 2003-2004

Adjunct Faculty, College of Nursing, Arizona State University, 1996-1997

Psychiatric Nurse Practice Council, Arizona State University, College of Nursing, 1995-Present

University of Phoenix®

University Services
1625 W Fountainhead Parkway
Tempe, Arizona 85282-2371

February 9, 2012

Bonnie J Marsh
[redacted]

To Whom It May Concern:

This letter serves to verify that Bonnie J Marsh graduated from University of Phoenix on 06/01/1991 with a Master of Arts in Organizational Management degree.

University of Phoenix is accredited by the Commission on Institutions of Higher Education of the North Central Association of Colleges and Schools (NCA) as of 1978.

North Central Association of Colleges and Schools
Commission on Institutions of Higher Education (NCA)
30 North Salle St Suite 2400
Chicago, Il 60602-2504
(312) 263-0456
www.ncahigherlearningcommission.org

This accreditation encompasses all University of Phoenix locations, including all United States and worldwide campus locations, as well as the Online campus based in Phoenix, Arizona.

If you have any questions regarding this information, please call our University Services Support Center at (800) 866-3919.

Sincerely,

Audra McQuarie
Registrar

AM/rh

University of Phoenix®

University Services
1625 W Fountainhead Parkway
Tempe, Arizona 85282-2371

February 9, 2012

Bonnie J Marsh
[redacted]

To Whom It May Concern:

This letter serves to verify that Bonnie J Marsh graduated from University of Phoenix on 11/01/1985 with a Bachelor of Science in Nursing degree.

University of Phoenix is accredited by the Commission on Institutions of Higher Education of the North Central Association of Colleges and Schools (NCA) as of 1978.

North Central Association of Colleges and Schools
Commission on Institutions of Higher Education (NCA)
30 North Salle St Suite 2400
Chicago, Il 60602-2504
(312) 263-0456
www.ncahigherlearningcommission.org

This accreditation encompasses all University of Phoenix locations, including all United States and worldwide campus locations, as well as the Online campus based in Phoenix, Arizona.

If you have any questions regarding this information, please call our University Services Support Center at (800) 866-3919.

Sincerely,

Audra McQuarie
Registrar

AM/ar

Debra L. Chotkevys, DHA, MBA
Project Director

Personal Information

Health Services Advisory Group, Inc.
Capitol Square Office Building
65 East State Street, Suite 1500
Columbus, Ohio 43215
614.221.2080
dchotkevys@hsag.com

Qualification Highlights

Dr. Chotkevys has more than 25 years of health care experience in compliance activities, hospital administration, physician services, marketing, credentialing, office site reviews, HEDIS® audits, medical record abstraction, and accreditation standards. She has been involved in external quality reviews (EQRs) for Medicaid managed care for the past ten years, reviewing quality and operational standards.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Director: Dr. Chotkevys is an EQR Project Director for HSAG's State & Corporate Services. She is responsible for the day-to-day compliance monitoring for HSAG's Florida contract; and overall EQR contract compliance for the Illinois, Nevada, and Tennessee contracts. Dr. Chotkevys also worked on EQR projects for HSAG in Ohio.

Dr. Chotkevys has a broad background and extensive knowledge of the quality and operational requirements established for Medicaid managed care organizations (MCOs) by the states and has participated in annual on-site reviews of health plans since 2000. Her knowledge of the MCOs is an invaluable asset when planning and conducting administrative compliance reviews. She has been instrumental in the design and development of focused studies performed by HSAG and has worked to ensure completion of the EQR projects as required by established timelines. Dr. Chotkevys coordinates with the HSAG statisticians and health analysts to ensure that interpretations of the focused studies include state-specific data, when possible. She has attended meetings with states, MCOs, and stakeholders to present findings from focused studies, administrative reviews, case management program reviews, encounter data studies, consumer satisfaction survey results, and performance improvement projects. Meeting attendance frequently includes monthly telephonic calls with the MCOs and presentations to various departments within the states. She also has conducted MCO information system readiness reviews and call center reviews. Dr. Chotkevys has provided numerous hours of technical assistance to the MCOs and state staff members.

Delmarva Foundation for Medical Care, Inc., Project Director for Ohio, Michigan, and West Virginia: Dr. Chotkevys was responsible for the overall operations of the EQR contract for three states, working with the states, MCOs and providers to assess and monitor care delivered to the Medicaid population. The contracts required conducting medical record abstraction for quality studies, performing on-site reviews at the MCOs, and providing technical assistance to the MCOs and state Medicaid bureaus. Projects included reviewing quality and operational standards of the MCOs to ensure compliance with provider contracts and state requirements during annual on-site audits; assisting in implementation of a waiver program to include medical record reviews for quality audits, provider site visits, and credentialing; designing and developing quality studies to monitor care; working with scientists, statisticians, and health analysts to interpret data; researching current literature and writing reports for quality studies; and presenting findings to state committees and MCO representatives.

As Senior Manager, Business Development in the Easton, Maryland office, Dr. Chotkevys was responsible for preparing responses to requests for proposals for new business opportunities at the state, regional, and national level with various state agencies and the Centers for Medicare & Medicaid Services (CMS). The position also included revising the credentialing system for Delmarva's network of physicians and allied health professionals.

Aperture Credentialing, Inc., Director: Job responsibilities included the management of projects involving physician credentialing, physician office site reviews, and medical record abstractions. Daily tasks included:

- Hiring and training registered nurses nationwide to assist in credentialing activities, HEDIS® audits, and quality studies for MCOs
- Utilizing a centralized scheduling team concept to schedule nurse reviewers for provider on-site surveys
- Developing, implementing, and maintaining quality standards
- Assisting with sales activities to generate new business
- Performing delegated audits according to National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the American Accreditation HealthCare Commission (URAC) standards

Experience

HSAG, Columbus, Ohio: Project Director, 03–Present

Delmarva Foundation for Medical Care, Inc., Columbus, Ohio: 00–03. Project Director for Ohio, Michigan, and West Virginia, (5/00–10/203); Senior Manager, Business Development, Easton, Maryland (1/00–5/00)

Aperture Credentialing, Inc., Louisville, Kentucky: Director, 1993–1999

Santa Rosa Health Care, San Antonio, Texas: 1983–1992. Director, Marketing (1991–1992), Director, Physician Services (1988–1991), Assistant Administrator and Manager of Human Resources at the system's psychiatric and physical rehabilitation hospital (1983–1988)

Education

Doctor of Health Administration Degree, University of Phoenix, Phoenix, Arizona

Master of Business Administration, Baldwin-Wallace College, Berea, Ohio

Bachelor of Music, Wittenberg University, Springfield, Ohio

University of Phoenix

Upon the recommendation of the Faculty,
University of Phoenix does hereby confer upon

Debra L. Chotkevys

the degree of

Doctor of Health Administration

with all the rights, honors and privileges thereunto appertaining.

In witness whereof, the seal of the University and the signatures as authorized by the Board of Directors, University of Phoenix, are hereunto affixed, this thirty-first day of December, in the year two thousand nine.

Chairman, Board of Directors

UNIVERSITY OF PHOENIX

President

Baldwin-Wallace College

This is to certify
that the Board of Trustees of Baldwin-Wallace College on the
recommendation of the faculty hereby confers upon

Debra C. Chotkevys

the Degree of

Master of Business Administration

with all the honors, rights and privileges thereunto appertaining.
In witness whereof this Diploma is sealed and signed by
the President and by the Dean of the College.

Given at Berea, Ohio, this month of June, nineteen hundred seventy-seven.

BALDWIN-WALLACE COLLEGE BEREA, OHIO

WITTENBERG UNIVERSITY

SPRINGFIELD, OHIO

THIS IS TO CERTIFY

THAT THE BOARD OF DIRECTORS OF WITTENBERG UNIVERSITY UPON THE

RECOMMENDATION OF THE FACULTY HEREBY CONFERS UPON

DEBRA L. CZOMPI CHOTKEVYS

THE DEGREE OF

BACHELOR OF MUSIC

WITH ALL THE HONORS, RIGHTS AND PRIVILEGES THEREUNTO

APPERTAINING.

IN WITNESS WHEREOF, THIS DIPLOMA IS SEALED AND SIGNED BY THE PRESIDENT
AND BY THE DEAN OF THE COLLEGE ON THE FOURTEENTH DAY OF JUNE,
NINETEEN HUNDRED AND SEVENTY.

L. David Miller
DEAN

PRESIDENT

Gretchen Thompson, MBA, CPHQ
Executive Director, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6850
gthompson@hsag.com

Qualification Highlights

Ms. Thompson has 14 years of experience in healthcare administration as well as extensive experience in health care policy and provides strategic direction for both profit and nonprofit entities which operate in Medicaid, Medicare and other publicly funded systems.

From 2005 to 2009, Ms. Thompson was President of Pinnacle Strategies, a private health care consulting firm with focus on strategic planning, business development, quality improvement, compliance, RFP response development, and Medicaid waiver program development and implementation. She was selected by the National Advisory Board on Improving Health Care Services for Seniors and People with Disabilities to author the community mobilization whitepaper, *Declaration for Independence: A Call to Transform Health and Long Term Services for Seniors and People with Disabilities*. Ms. Thompson was also a member of the Heinz Family Philanthropies consulting team for projects involving 340B research and analysis and health care reform.

Prior to joining HSAG, Ms. Thompson also provided consulting to HSAG on its EQRO activities in several states, including the preparation of EQR Technical Reports and Provider Network Quality Management and Utilization Management (QM/UM) Evaluation.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Executive Director, State & Corporate Services: Ms. Thompson is responsible for leading or serving as a resource for designated State and Corporate Services' projects and acts as a contract liaison and directs EQRO activities for individual states. She oversees the development of all project deliverables, and is responsible for the quality of all work performed by project staff, ensuring client satisfaction with the work product provided. She coordinates projects through various stages using internal and external resources to achieve project goals and objectives. Ms. Thompson develops collaborative partnerships with state Medicaid managed care agencies to address the individual needs of the state's quality review program.

Pinnacle Strategies, LLC, President: Provided professional consulting services to healthcare organizations and government entities. Directed the successful operation of client projects, ensure that project timelines are met, and ensure deliverables are accurate, timely and professional.

Prepared journal articles for publication on the following topics: improving health care for seniors and people with disabilities; modernizing the social service system to empower people with disabilities; and removing disincentives to work for people with disabilities. Provided strategic direction and business development for Medicaid managed care programs for a national managed care organization. Developed and wrote EQR technical reports, analysis reports of state waivers, and grant proposals.

AmeriChoice, a subsidiary of UnitedHealth Group, Senior Development Specialist/Client Lead: Planned, developed, and oversaw technical responses to government issued RFPs. Directed meetings with Medicaid directors, legislators, and key stakeholders to develop high quality cost-savings health care programs for TANF and aged, blind/disabled (ABD) populations. Directed meetings and led cross-functional teams charged with designing and implementing public sector health care programs. Conducted research and wrote summaries of new health care program initiatives in Medicaid and other public sector health care programs. Served as Client Lead for southwest region.

Previous Experience

HSAG, Phoenix, Arizona: Executive Director, State & Corporate Services; 2/09–Present

Pinnacle Strategies, LLC, Chandler, Arizona: President; 9/05–2/09

AmeriChoice, Phoenix, Arizona: Senior Development Specialist/Client Lead; 5/02–11/05

Maximus Inc., Waltham, Massachusetts: Consultant; 10/01–5/02

Pinal Gila Behavioral Health Association, Apache Junction, Arizona: Performance Improvement Coordinator (3/98–10/00); Director of Special Programs for Adults (10/00–10/01); 3/98–10/01

Education

Masters of Business Administration, University of Phoenix, Phoenix, Arizona, 2001

Bachelor of Arts in Psychology, Arizona State University, Tempe, Arizona, 1997

Certifications, Professional Organizations, and Publications

Certifications

Certified Professional in Health Care Quality (CPHQ) by the Healthcare Quality Certification Board, 2000–Present

Professional Organizations

Board Member/Strategic Director, Neurofibromatosis Association of Arizona, November 2005–Present
Arizona Public Health Association, 2006–Present
Arizona Association of Healthcare Quality (AzAHQ), 2006-Present

University of Phoenix

Upon the recommendation of the Faculty,
the University of Phoenix does hereby confer upon

Gretchen L. Johnson-Penner

The Degree of

Master of Business Administration
Health Care Management

with all the rights, honors and privileges thereunto appertaining.

In witness whereof, the seal of the University and the signatures as authorized by the Board of Directors, University of Phoenix, are hereunto affixed, this thirty-first day of October, in the year two thousand and one.

UNIVERSITY OF PHOENIX

Chairman, Board of Directors

President

Healthcare Quality Certification Board

This Certifies That

Gretchen L. Johnson

Having met the standards established by the Healthcare Quality Certification Board and passed the written examination has attained the designation of

Certified Professional in Healthcare Quality

On this 1st day of January, 2000

Dorothy A. Human
Chairman of the Board

1, 2001

RECERTIFIED THROUGH DECEMBER 31, 2005

CPHQ No. 9268

Healthcare Quality Certification Board
of the National Association for Healthcare Quality
P.O. Box 19504 • Lenexa, KS 66285
(913) 895-4600 • Fax: (913) 895-4652
Toll Free 1-800-346-4722

HQCB

CPHQ ID#: [redacted] Expires: 12/31/2011

Gretchen L. Johnson, CPHQ

[redacted]

HQCC is pleased to enclose your CPHQ card. Your support is essential to the growth and progress of the Healthcare Quality Certification Commission. If the information below is incorrect, please note changes and return to: **HQCC, 4700 West Lake Ave., Glenview, IL 60025.**

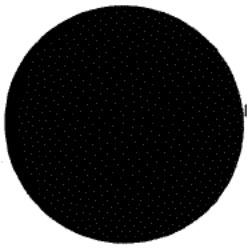
Healthcare Quality Certification Commission
of the National Association for Healthcare Quality
4700 West Lake Ave. • Glenview, IL 60025
800.966.9392 • Fax 847.375.3620

HEALTHCARE QUALITY CERTIFICATION COMMISSION

CPHQ ID#: [redacted] **Expires:** 12/31/2013

Gretchen L. Johnson, CPHQ

[redacted]



Remove this validation sticker and place it on your permanent certificate.

HEALTHCARE QUALITY CERTIFICATION COMMISSION

THANK YOU FOR YOUR ONGOING COMMITMENT TO THE CPHQ PROCESS.

Perforated at your left is your CPHQ card which includes your personal CPHQ number. This card is to be used to verify your CPHQ designation and status.

NAHQ

NATIONAL ASSOCIATION FOR HEALTHCARE QUALITY

January 9, 2012

Gretchen Thompson
[redacted]

Dear Gretchen Thompson,

Welcome to the National Association for Healthcare Quality (NAHQ), the *only* organization to offer comprehensive diversity in *all facets* of the healthcare quality arena. NAHQ is committed to your success and offers resources to enhance your career in healthcare quality. In addition, NAHQ is the first and sole provider of the highly regarded Certified Professional in Healthcare Quality (CPHQ) credential through its certifying arm, the Healthcare Quality Certification Board (HQCB).

Listed below are a number of the many member benefits:

- ***Journal for Healthcare Quality (JHQ):*** bi-monthly, peer-reviewed journal
- ***NAHQ E-News*:** monthly electronic newsletter
- **Free *JHQ* CE:** available all year
- **NAHQ's Annual Educational Conference:** informative sessions and networking, September 20-23, 2012 in Tampa, FL.
- **Discounts:** annual conference registration, audio conferences, publications, & CPHQ exam
- **Special Interest Groups (SIGs):** member-driven online networking
- **Membership Directory and Resource Center:** (an archive of policies and procedures) log-in to the members-only site; register your e-mail and password using your last name and member ID number, **00152123**. Each time you visit the site, use your e-mail address and the password you've created.
- **New Member Calls:** learn more about NAHQ and join other new members on calls scheduled for in 2012

Thank you for joining NAHQ. Please contact us at info@nahq.org if you have questions or suggestions on how we can serve you better.

Together, we define excellence in healthcare quality.

Very truly yours,

Betty Brown

Betty Brown, MBA MSN RN CPHQ FNAHQ
President

4700 W. Lake Avenue ■ Glenview, IL 60025-1485
800/966-9392 ■ 847/375-4720■Fax 847/375-6320
info@nahq.org ■ www.nahq.org

NAHQ

4700 W LAKE AVE GLENVIEW, IL 60025
(800)966-9392 FAX (847)375-6320
info@nahq.org www.nahq.org

THIS IS TO CERTIFY THAT
GRETCHEN THOMPSON

IS A MEMBER IN GOOD STANDING
MEMBER ID# [redacted]

EXPIRATION DATE 11/30/2012

Wendy Talbot, MPH, CHCA
Associate Director, Audits

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016
602.801.6846
wtalbot@hsag.com

Qualification Highlights

Ms. Talbot has more than eight years of experience in epidemiology, data analysis and management, state Medicaid programs, and health care/disease program management. She holds a master's degree in Public Health from the University of Arizona, with emphasis in epidemiology.

As a Project Manager for the Arkansas contract, Ms. Talbot was responsible for the day to day operations and management of the contract requirements. Ms. Talbot is skilled in project management, Medicaid EQR activities, and contract oversight.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Associate Director, Audits: Ms. Talbot has day-to-day responsibility for the oversight and management of HSAG's NCQA HEDIS® Compliance Audit™ activities and staff of NCQA-Certified HEDIS Compliance Auditors (CHCAs) and support personnel. She is also responsible for the oversight the performance measure validation activities for HSAG's external quality review contracts.

Project Manager: Ms. Talbot is the project manager for the Arkansas Medicaid Data Mining and Evaluation contract. Her responsibilities in this role include communication and coordination with the State contract manager, communication with providers, and coordination and oversight of subcontractor's performance and deliverables; as well as all aspects of contract requirements.

Health Services Advisory Group, Inc. (HSAG), Project Manager, Audits: Ms. Talbot is a certified HEDIS compliance auditor and is responsible for all activities related to performing HEDIS audits for Medicaid, Commercial, and Medicare health plans. This includes communicating with health plans, preparing agendas and scheduling site visits, reviewing health plan completed systems capabilities tools, programming logic and output files, and compiling audit results into a final audit reports for HSAG's HEDIS audit program and performance measure validation activities. Ms. Talbot has also performed Annual Network Adequacy audits for HSAG's Medicaid EQR activities for the Bureau of TennCare.

In her previous role as Project Coordinator for Medicaid Performance Improvement Projects, she performed validation of physical and behavioral health Performance Improvement Projects (PIPs), and participated on external quality review and compliance audits of Michigan Medicaid Mental Health plans. As a healthcare analyst, she provided analytic support for the CMS 7th Scope of Work Quality Improvement Organization (QIO) contract. She analyzed and reported on ambulatory care and inpatient data, including, but not limited to, mammography, diabetes and immunizations.

Arizona Department of Health Services (ADHS), Comprehensive Cancer Control (CCC) Epidemiologist: Conducted statewide community needs assessments of cancer control efforts and needs of Arizona residents. Determined gaps in and opportunities for services. Analyzed needs assessment results for the purpose of including in the CCC State plan. Presented data to key committee members. Collaborated with external organizations (Indian Health Services, American Cancer Society, Arizona's Medicare program, Arizona Cancer Center) to assess strategies for CCC planning.

National Breast and Cervical Cancer Early Detection Program Data Manager: Provided epidemiological and data support. Conducted routine analysis of database to ensure data accuracy and completeness. Technical maintenance of the database (upgrades). Monitored and assessed quality control of patient care and services and ensure services are being provided according to protocol guidelines. Provided program protocols and updates, and maintained clinical guidelines. Provided oral and written data reports and updates to program staff, contractors, and other interested parties. Prepared biannual data submission and narrative to the Centers for Disease Control and Prevention. Prepared NBCCEDP interim progress report and continuation grant; including budgets and work plans. Updated the program's income guidelines and Medicare reimbursement rates. Worked with the state Medicare Program on the Breast and Cervical Cancer Treatment Program. Collaborated with the American Cancer Society on maintaining the Program's hotline.

Arizona Asthma Program Epidemiologist: Analyzed hospital discharge and Behavioral Risk Factor Surveillance asthma data for the state of Arizona. Provided data to interested parties. Generated county specific reports and statewide reports. Offered epidemiology services to other chronic disease programs in the Office of Prevention and Health Promotion, including the Diabetes Prevention Program, Rape and Domestic Violence Program, and Injury Prevention Program.

Previous Experience

HSAG, Phoenix, Arizona: Associate Director, Audits (8/11–present); Project Manager, Audits (7/08–present); Project Leader, Audits (8/06–6/08); Project Coordinator, PIPs (1/05–8/06); Healthcare Analyst II (6/04–1/05);6/04–Present

ADHS, Phoenix, Arizona: CCC Epidemiologist (1/03–5/04); National Breast and Cervical Cancer Early Detection Program Data Manager; Health Program Manager (1/02–1/03); Arizona Asthma Program Epidemiologist (10/01–6/02); 10/01–6/04

University of Arizona, Tucson, Arizona: Researcher (6/01–9/01); Southeastern Tea Study Coordinator (5/00–9/01); Internship (9/00–8/01); Telephone Interviewer/Surveyor (1/00–5/00); 1/00–9/01

University of Nevada, Reno, Nevada: Teaching Assistant, 8/98–12/98

Education

MPH with concentration in Epidemiology, University of Arizona, Tucson, Arizona, August 2001

BS in Health Sciences, University of Nevada, Reno, Nevada, May 1999

Certifications, Professional Organizations, and Publications

Certifications

NCQA-Certified HEDIS® Compliance Auditor, 10/07–Present

Publications/Papers

Hakim IA, Harris RB, Brown S, Rodney S, Talbot W, Loffredo V, Ford L. (2001) Effect of increased tea consumption on oxidative DNA damage among smokers. Society for Epidemiologic Research; June 2001. *Am J Epidemiol* 2002; S345.

"Arizona Asthma Report – 2002." Annual report of asthma incidence and prevalence in Arizona. Arizona Department of Health Services, June 2002.

"Statewide Injury Prevention Plan – Chapters on Homicide and Violence Against Women." Arizona Department of Health Services, June 2002.

"Diabetes Summary Report; 2000." A brief overview of the results from the Behavioral Risk Factor Surveillance System Survey. Arizona Department of Health Services, April 2002.

"Amputation Risk Reduction Project." Poster presented at the Annual Diabetes Translation Conference. St. Louis MO, May 2002.

"Skin Cancer as a Predictor for Subsequent Invasive Cancer." Masters of Public Health Internship Report. August 2001

"Skin Cancer as a Predictor for Subsequent Invasive Cancer." Poster

presented at the Arizona Cancer Center Poster Session. Tucson AZ, August 2001.

"Does Amount of Cigarette Smoking Affect the Degree of Oxidative Damage among Smokers?" (*Preliminary Data*) Poster presented at the Annual College of Public Health Epidemiology Forum. Tucson AZ, April 2001.

Asset mapping on nutritional and exercise programs available to senior citizens in the Tucson, AZ area. Report presented May 2000.

The University of Arizona

The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Wendy A. Talbot

who has satisfactorily completed the Studies prescribed therefor the degree of

Master of Public Health

with all the Rights, Privileges, and Honors thereunto appertaining.
Awarded at Tucson, this ninth day of August 2001.

Governor of Arizona

President of the Board

Sigillum Universitatis Arizonensis 1885

President of the University

Dean, College of Public Health

NCQA
Measuring quality
Improving health care

National Committee for Quality Assurance

is pleased to announce

Wendy Talbot

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2011	10/31/2013
DATE CERTIFIED	EXPIRATION DATE

Thomas Cross, MBA
Auditor – HEDIS, Performance Measure Validation, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6844
tcross@hsag.com

Qualification Highlights

Mr. Cross has more than 10 years combined experience in supervising managed care in the areas of Long-Term Care, Behavioral Health and Developmental Disabilities, specializing in analyzing data for trends and solutions, reviewing software systems that create and track authorizations, billing and claims, and reporting to governing bodies. He is also skilled at creating and implementing policies and procedures to regulate user access and responsibilities.

Mr. Cross also has experience as an administrator of a home care agency, and holds a Master of Business Administration degree from Ottawa University.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Auditor – HEDIS, Performance Measure Validation, State & Corporate Services: Mr. Cross is responsible for general audit-related activities including implementation, project management, analysis, reporting, orientation and training. Additionally, he is responsible for assisting lead auditors with pre-onsite, onsite and post-onsite activities for HSAG's HEDIS and External Quality Review Organization (EQRO) contracts.

The Crossroads Home Care, Owner/Administrator: Mr. Cross was responsible for collecting, analyzing and reporting survey data to applicable state and national governing bodies.

Bridgeway Health Solutions, Supervisor- LTC Case Management: Mr. Cross was responsible for gathering data for non-provisions of service (NPR) as it pertained to contracted provider responsibilities and reporting to state governing bodies.

Previous Experience

HSAG, Phoenix, Arizona: Auditor –HEDIS, Performance Measure Validation, State & Corporate Services; 4/11–Present

The Crossroads Home Care, Phoenix, Arizona: Owner/Administrator; 2009–2011

Bridgeway Health Solutions, Tempe, Arizona: Supervisor- LTC Case Management; 2008

Aetna/Schaller Anderson/MercyCare Plan, Phoenix, Arizona: Long-Term Care Case Manager; 2006–2008

ValueOptions, Phoenix, Arizona: Supervisor - Outpatient Behavioral Health Team; 2004–2006

Education

Master of Business Administration, Business, Ottawa University, 2008

Bachelor of Arts, Psychology, FWBBC Nashville, 1998

Ottawa University

Ottawa, Kansas

The Board of Trustees
upon the recommendation of the Faculty
hereby confers upon

Thomas Robert Cross

the degree of

Master of Business Administration

with all the rights and privileges pertaining thereto.

February, A.D. 2009

Chair, Board of Trustees

University President

Ron Holcomb, AS
Source Code Reviewer Consultant

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.264.6382
cholcomb@hsag.com

Qualification Highlights

Mr. Holcomb has 10 years' experience performing source code review for HEDIS and performance measure validation audits. Mr. Holcomb has a broad knowledge base in multiple programming languages and more than five years' experience working with behavioral health source code.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Source Code Auditor:

- Develop health care applications for a Novell/Oracle environment & IBM 4381 mainframe.
- Systems Analysis
- Audit code from other vendors.
- Test & Debug programs, solve complex programming problems.
- System and network support and backups on a local area network.
- Documentation.
- Performed maintenance on legacy systems.
- Statistics.
- Design, maintain & analyze reports.
- Software presentations to potential buyers.
- Evaluate, supervise & guide a team of system application specialists.
- User and programmer training.
- Hardware management, maintenance & trouble shooting.
- Relational database management.
- Analyze automation & user needs.
- Conduct new employee interviews.
- Supervise contract and temporary employees.
- Perform major enhancements to existing systems.
- Work with consultant for marketing and research of software products.

Arizona Department of Water Resources/ITS, Programmer Analyst III:

- Develop Client Server applications for an Oracle database using Delphi and Oracle Forms.
- Develop Web applications with Delphi to a SQL Server database.
- Develop Web applications with Visual Studio 2008 to an Oracle database.
- Systems Analysis.
- Test & Debug programs and solve complex programming problems.
- Documentation.
- Customer Service.
- Develop Oracle Web Security protocols.

- Design, maintain & analyze reports.
- Relational database management.
- Major enhancements to existing systems.
- Database Design.
- Customer Demos and Training.
- Migrate Access databases to Oracle

Arizona Department of Health Services/ITS/WIC, Programmer Analyst III:

- Develop applications for a Novell/Oracle environment.
- Systems Analysis.
- Test & Debug programs, solve complex programming problems.
- Documentation.
- Develop standalone applications for the WIC clinics.
- Consult and audit contractor developing statewide WIC system.
- Statistics.
- Customer Service.
- Ensure quality data is provided to the Center for Disease Control.
- Design, maintain & analyze reports.
- Administer Oracle Discoverer for the agency.
- Relational database management.
- Conduct new employee interviews.
- Major enhancements to existing systems.

MeraBank, Systems Specialist:

- Application programming/development for a Novell network and IBM 3090 mainframe
- System and network support on a local area network
- Maintain budgets and operating statements for over 80 properties
- Relational database management
- Design, maintain & analyze reports
- Test & Debug programs
- Hardware management, maintenance & trouble shooting
- Generate audit reports for the Resolution Trust Corporation.

Previous Experience

HSAG, Phoenix, Arizona: Source Code Auditor (9/97–Present); Programmer Analyst (2/91–9/97); 2/91–Present

Arizona Department of Water Resources/ITS, Phoenix, Arizona: Programmer Analyst III; 12/00–Present

Arizona Department of Health Services/ITS/WIC, Phoenix, Arizona: Programmer Analyst III; 9/97–12/00

MeraBank: Systems Specialist; 1987-2/91

Education

Associate Science Degree in Computer Data Processing, Mountain States Technical Institute, 1986

Technical Experience

- A member of a team that won the Arizona Spirit of Excellence Award for 2002.

- Employee Of The Year Awards at MeraBank, HSAG and ADHS ITS.
- A member of a team who won the "Team Of The Year" Award.
- Designed an Image storage application in Delphi that saves the images in Oracle.
- Part of a team to develop ADWR's first Web Application using Visual InterDev.
- Researched, analyzed, developed and tested a Delphi system to load data into an Oracle database.
- Part of a team to develop the transactional processing for a PenTab Delphi/Oracle application.
- Researched, analyzed, developed and tested tracking systems using a barcode reader.
- Co-Project Manager in complex case management system on Novell using Paradox Dos/Windows. Included working with users in analysis and provided system testing and documentation.
- Designed and implemented Inventory storage application on Novell using Paradox in Windows.
- Developed standards for application development.
- Part of team to convert a precertification system and data from mainframe to PC.
- Automated all client savings reports.
- Designed and maintained an asset recovery budget and operating application on Novell using Paradox in DOS.
- Developed many new health care data entry programs for DOS and Windows environments, this was done by translating project specifications and user interviews.
- Co-Project Manager in project to make extensive modifications to existing Utilization Management system which included conversion of existing data.
- Member of a Continuous Quality Improvement Team at HSAG and ADHS ITS.
- Part of team to evaluate new technology.
- Participate in feasibility and system studies

Hardware & Software Experience:

Microsoft Visual Studio	Paradox	Visual Web Developer	Visio	SQL
Delphi/Pascal	HTML	Oracle Developer	PowerPoint	JCL
ASP.net	SQL Server	D-Base	Oracle Forms	UNIX
GIS	SQL Loader	Oracle Designer	Oracle Reports	TSO
IIS	Access	Ace Reports	Oracle Discoverer	XML
C#	Java	Excel/Quattro	Dreamweaver	PL/SQL
Report Builder	WordPerfect/Word	Easytrieve+	Visual Basic	SQR
Cobol	SharePoint	Microsoft Project	Visual InterDev	SAS

Tammy GianFrancisco
Project Coordinator, Audits/State and Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6841
tgianfrancisco@hsag.com

Qualification Highlights

Ms. GianFrancisco brings more than 10 years of experience in project support and coordination. She coordinates all Healthcare Effectiveness Data and Information Set (HEDIS), performance measure validation (PMV), and pay-for-performance (P4P) audit activities throughout all stages of the process. These stages include contract preparation and management, as well as monitoring and tracking the completion and submission of all audit activities. Ms. GianFrancisco ensures that internal and external timelines/deliverables are met, and she is the audit team's main point of contact for health plans, HEDIS and PMV contacts, and physician organizations.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Coordination, Audits/State and Corporate Services: Ms. GianFrancisco coordinates and participates in audit activities during all stages of the process for state EQRO and private contracts. She drafts all audit correspondence, is responsible for the audit schedule, and helps develop processes. Ms. GianFrancisco also assists with managing source code review for the PMV, HEDIS, and P4P audit activities, ensuring the use of accurate specifications. She monitors the completion of all audit activities, develops and adheres to project timelines, identifies opportunities for process and quality improvement internally as well as with states and health plans, and coordinates audit reports. Through these efforts, she ensures that state, plan-specific, and National Committee for Quality Assurance (NCQA) guidelines are met, when applicable.

Ms. GianFrancisco is responsible for coordinating all NCQA-related activities for HSAG's certified auditors so that timelines and requirements are met. She is responsible for the preparation and management of all contracts with private clients and consultants for the audit department, updates Executive Directors for state EQRO contracts on the progress of audit activities, and develops and maintains audit contact lists at the state and plan levels.

Ms. GianFrancisco also assists the performance improvement project (PIP) team with validation of reported HEDIS and PMV rates to help ensure accuracy and determine discrepancies with PIP rate submissions. She also provides technical and audit assistance to state audit clients,

health plans, and internal departments, and provides administrative support to the audit team.

Previous Experience

HSAG, Phoenix, Arizona: Project Coordinator, Audits/State and Corporate Services; 3/03–Present

Cardinal Health, Inc., San Diego, California: Executive Assistant to Vice President of Quality and Vice President of Communications; 6/02–1/03

New Horizons, Tempe, Arizona: Operations Assistant; 9/98–4/02

Choice Cellular Communications, Phoenix, Arizona: Customer Service; 8/95–10/96

Allstate Cellular Communications, San Diego, California: Office Manager and Assistant Store Manager; 1/90–8/95

Education

Palomar Community College; Mesa Community College: Business Administration and Psychology.

Technical Experience

Proficient in the Microsoft Office Suite programs, Internet research, file transfer protocol site maintenance, and use of an Access database. Types 80 words per minute, with a 99 percent accuracy rate, and is familiar with various source code program applications.

Marilea Rose, RN, BA
Associate Director, State & Private Projects

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6890
mrose@hsag.com

Qualification Highlights

Ms. Rose has more than 30 years of experience in the health care industry, as a registered nurse in the clinical setting, in home health, and in quality improvement. Her current role as Associate Director includes the recruitment, selection, orientation, training, and ongoing quality oversight of HSAG's RN medical record abstractors. She is vital in developing integrated data collection and procurement tools and establishing robust quality control systems and processes.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), **Associate Director, State & Private Projects**: Oversees the State & Corporate Services study projects team and HEDIS medical record review team. Her responsibilities include management of project stages including proposal development, design, methodology, implementation, project management, analysis, reports, recruitment selection, orientation and training. In her previous positions as Project Manager and Project Leader, Ms. Rose coordinated the medical record review process for HEDIS-related medical record review activities, encounter data review projects, and EQRO quality studies, which were focused on a clinical record review designed to measure adherence to established guidelines and standards. Ms. Rose offers clients a core competency in synthesizing sound methodological principles and study designs in "real world clinical settings." Combined with her analytic insights, she is responsible for developing actionable recommendations and interventions.

GentivaHealth Services, **Intake Prior Authorization Specialist and Case Manager**: Compiled and coordinated adequate patient data, assessed appropriateness for home care, verified insurance benefits, and assigned appropriate provider. Maintained continuity of care via communication with discharge planners and care managers using cost-effective case management. Extensive after-hours management of emergency issues related to on-call position for nationwide accounts.

Dr. Millard P. Thaler, **Office Manager and Surgical Assistant**: Marketed, negotiated, and implemented managed care contracts into the practice. Supervised employees, implemented Federal OSHA/CLIA standards and manual. Increased revenues through collections, proper insurance coding, and marketing strategies. Nursing duties included surgical assistant, teaching, lab assessment, and follow-up care.

Previous Experience

Health Services Advisory Group, Inc., Phoenix, Arizona: Associate Director, State & Private Projects (2/07–Present); Project Manager (2/05–2/07); Project/Team Leader (1/01–2/05); Project Coordinator (5/00–1/01); Medical Record Abstractor (10/97–5/00); 10/97–Present

Gentiva Health Services, Phoenix, Arizona: Intake Prior Authorization Specialist (1996–9/97), Home Health RN (1994–1997)

Dr. Millard P. Thaler: Office Manager and Surgical Assistant; 1990–1994

Women's Community Health Center: RN Clinician/Educator; 1987–1990

Dr. Frank Simchak: RN Clinician/Educator; 1983–1987

Normandy Hospital, South St. Louis, Missouri: Obstetrical RN; 1980–1983

Education

BA in Management, Ottawa University, Phoenix, Arizona, 2005

Associate Degree in Nursing, Maryville University, St. Louis, Missouri, 1980

Certifications, Professional Organizations, and Publications

Certifications

Certification in Obstetrical Nursing, American College of Obstetrics and Gynecology, 1986

Certified Childbirth Educator, American Society for Psychoprophylaxis in Obstetrics, 1983

Established the Cesarean Support Group of St. Louis, 1977–80

Ottawa University

Ottawa, Kansas

The Board of Trustees
upon the recommendation of the Faculty
hereby confers upon

Marilea C. Rose

the degree of

Bachelor of Arts

with all the rights and privileges pertaining thereto.

August, A.D. 2005

Stanley L. Bellis, D.D.
Chair, Board of Trustees

James C. Billick
President

Maryville College

Saint Louis

To all to whom
these letters shall come greeting.
The Trustees of the College on the recommendation of the Dean and the Faculty
and by virtue of the authority in them vested have conferred on

Mary Lea Kolaga

the degree of

Associate of Arts in Nursing

With all the rights, privileges and honors thereunto appertaining.
In witness whereof this diploma has been signed by the officers of the college
and sealed at St. Louis, Missouri, on the fourth day of May
in the year of our Lord, nineteen hundred and eighty.

Ronald E Hayes
Chairman, Board of Trustees

President

Maryville College Saint Louis 1872

Patricia Thro RSCJ
Academic Dean

ARIZONA STATE BOARD OF NURSING
4747 N. Seventh Street, Suite 200
Phoenix, AZ 85014-3653
(602) 889-5150

RN RENEWAL License issued to

ROSE, MARILEA C
[redacted]

Signature: Marilea C. Rose

RENEWAL DUE DATE	LICENSE NO.
06/30/2012	[redacted]

Lora Wagner, MEd
Project Manager, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6892
lwagner@hsag.com

Qualification Highlights

Ms. Wagner has more than 20 years of experience in case management, case review/abstraction, and social work. She has worked in both the private sector (managed care) and government, providing case management, eligibility determinations, and clinical assessments for patients in long-term care and rehabilitative settings.

Ms. Wagner holds a Bachelor of Arts in Social Work from the University of Montana and a Masters of Education in Counseling from Northern Arizona University.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Manager, State & Corporate Services: In addition to project management, Ms. Wagner is responsible for management and daily oversight of medical record review activities for a variety of HSAG contracts, including monitoring project time and task schedules; identifying opportunities for quality improvement of project-related processes; and developing and delivering review activity training. She also performs compliance audits in a number of states.

AlohaCare, Manager, Case Management: Responsible for managing the daily operations of the Case Management and Behavioral Health Departments for a Hawaii-based health plan according to contractual guidelines; participated in the organization's quality improvement initiatives; participated in the following quality improvement processes and audits: HEDIS, performance improvement projects, and external quality reviews; responsible for department compliance with established standards and guidelines; contributed to development and implementation of the Medicare product line including establishing departmental processes according to CMS guidelines.

Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term (ALTCS), Programs and Projects Specialist II: Evaluated applicants to determine medical eligibility for long term care program using a standardized tool; completed concise reports using agency automated systems; requested, reviewed, and interpreted records; coordinated with physicians providing medical review; consulted with state and community organizations; provided information and referrals to consumers; represented the agency in outreach; interpreted federal and state regulations and

maintained agency standards; provided orientation and guidance to program applicants; attended extensive medical training offered by the agency.

Previous Experience

HSAG, Phoenix, Arizona: Project Manager, State & Corporate Services (7/11–present); Project Leader (2006–6/11); Project Coordinator—Pool staff (2003–2004)

AlohaCare, Honolulu, Hawaii: Manager, Case Management; 10/04–1/06

Desert Care Therapy, Phoenix, Arizona: Contract Social Worker; 4/02–5/04

Select Specialty Hospital, Phoenix, Arizona: Social Worker/Case Manager; 9/00–4/02

AHCCCS, **ALTCS**, Glendale, Arizona: Programs and Projects Specialist II 7/98–12/99

Arizona Department of Economic Security (DES), Rehabilitation Services Administration, Chandler, Arizona: Rehabilitation Specialist III (1/95–7/98); **Division of Developmental Disabilities**, Mesa, Arizona: Human Service Specialist II (12/93–1/95); **Child Care Administration**, Phoenix, Arizona: Human Service Specialist I (11/91–12/93); 11/91–7/98

Education

MEd, Counseling, emphasis in Human Relations, with distinction, 4.0 GPA, Northern Arizona University, Phoenix, Arizona, 12/00

BA, Social Work, University of Montana, Missoula, Montana, 6/91

Northern Arizona University

The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Lora Jean Wagner

who has satisfactorily completed the Studies prescribed therefore
the Degree of

Master of Education

Counseling

WITH DISTINCTION

with all the Rights, Privileges and Honors pertaining to this degree,
awarded this fifteenth day of December, 2000.

Governor of Arizona

President of the Board

President of the University

Registrar of the University

Maricris Kueny
Project Coordinator, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6891
mkueny@hsag.com

Qualification Highlights

Maricris Kueny is a Project Coordinator for State & Corporate Services, providing support and coordination for quality studies and HEDIS medical record review activities. Ms. Kueny also develops and adheres to project timelines and task schedules. She provides coordination and support for EQRO and HEDIS activities, from study design through final deliverables.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Coordinator, State & Corporate Services: Ms. Kueny coordinates and participates in all project deliverables by developing timelines, tracking medical records and ensuring that all documents are submitted in compliance with HIPAA standards. She is the liaison between HSAG and clients and assists in developing and providing training programs related to medical record activities.

Previous Experience

HSAG, Phoenix, Arizona: Project Coordinator, State & Corporate Services (6/11–present)

HSAG, Phoenix, Arizona; Administrative Assistant II (3/02–05/11)

American Express, Phoenix, Arizona: Customer Service, Small Business Services; (9/00–02/01)

Arrowhead Towne Center, Glendale, Arizona: Customer Service Representative; (10/97–05/00)

Education

Estrella Community College; Business Administration and Pre-Nursing classes

Technical Experience

Proficient in Microsoft Office program use, Internet research, and file transfer protocol site maintenance.

David D. Mabb, MS, CHCA
Associate Director, State & Corporate Services
NCQA-Certified HEDIS® Compliance Auditor (CHCA)

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6843
dmabb@hsag.com

Qualification Highlights

Mr. Mabb began his career at HSAG more than 15 years ago, and has extensive experience with all aspects of study designs. He has conducted literature research, appropriate project development and design, sampling, tool development, programming, data analysis with interpretation of the results, scoring methodologies, and preparation of reports for state Medicaid programs. He has conducted analysis on Medicaid and Medicare data and produced reports for over ten years, and helped to establish minimum and high performance levels for Medicaid health plans. Mr. Mabb has developed "report card" type analysis for state Medicaid programs, including comparisons to various benchmarks, such as NCQA National Medicaid Averages, regional averages, and state-defined minimum and high performance levels. Mr. Mabb has served as project manager, and from 1999 through 2001 was manager of the State and Corporate analysts at HSAG.

He has been an NCQA Certified HEDIS Compliance Auditor (CHCA) since 1999, and has conducted more than 120 audits on Medicaid, Medicare, commercial health plans, and pay-for-performance audits for provider groups. These HEDIS compliance audits include a complete assessment of a health plan's system, including enrollment, provider data, credentialing data, computer programming, and claims and encounter data validation.

Between 1999 and 2003, Mr. Mabb was responsible for the management of the source code review for the HEDIS audits, ensuring accurate and timely evaluations for each health plan's programming code. The responsibilities for this position included overseeing the source code reviewers, development of tools for the source code review team, providing direct feedback to the health plans, and personally reviewing source code for accuracy.

Mr. Mabb has also helped to produce HEDIS rates each year between 2000 and 2005 for the state of Colorado Medicaid PCPP and FFS programs. To ensure these rates were produced in accordance with the HEDIS Technical Specifications, an independent CHCA (outside of HSAG) audited Mr. Mabb's work as part of the HEDIS audit for the state

each year. This included validating the results as well as ensuring a proper and easily traceable documentation trail was in place. The auditing experience (both conducting audits and being audited himself) has provided Mr. Mabb with a unique perspective in understanding and reporting HEDIS.

His experience in the behavioral health field includes conducting audits for Michigan and Utah. He has also worked on projects in the behavioral health setting with the Arizona Department of Health Services and their contracted health plans for several years.

Mr. Mabb has completed a master's degree in applied statistics, decision and information systems, from Arizona State University, a bachelor's degree in mathematics from the University of Texas at Arlington (UTA), and an associate's degree from Eastfield College in Mesquite, Texas. Mr. Mabb passed Exam 100 with a score of 9 from the Society of Actuaries.

In his current role, Mr. Mabb is an Associate Director of EQRO Services, working primarily with the state of Nevada and Illinois. He is also part of the validation team for performance improvement projects conducted by health plans.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc., (HSAG), Associate Director, EQRO Services: Under the supervision of the Executive Director, State & Corporate Services, Mr. Mabb is actively involved in day-to-day communication with the State of Nevada and Illinois state project management staff. He provides technical assistance in the development and review of pay-for-performance methodologies, developing performance measures, implementation of performance tracking tools, presentations on the results of EQRO activities and provision of technical assistance sessions at both the plan and state level. He coordinates internal and external resources to achieve contracts goals and objectives. Mr. Mabb also is responsible for accurate and timely deliverables.

In his previous role as **Senior Director, Statistical Evaluation**, his primary responsibilities included project development and design, sampling, analysis of data, and preparation of reports for state Medicaid programs. Since 2001, Mr. Mabb has been the primary statistician for the Colorado Medicaid EQRO, utilizing the STARS database to manipulate and clean data for focused studies and HEDIS measures calculations. He has conducted analysis on Medicaid data, produced reports for nearly ten years, and helped to establish minimum and high performance levels for Medicaid health plans. Mr. Mabb has developed "report card" type analysis for state Medicaid programs, including comparisons to various benchmarks, such as NCQA National Medicaid Averages, regional averages, and state-defined minimum and high performance levels.

In addition, Mr. Mabb has been an NCQA-Certified HEDIS Compliance Auditor for the past five years, and has conducted more than 50 audits on

Medicaid health plans. These HEDIS compliance audits include a complete assessment of a health plan's system, including enrollment, provider data, credentialing data, computer programming, and claims and encounter data validation. The auditing experience has provided Mr. Mabb with a unique perspective in understanding and reporting on Medicaid data. Mr. Mabb serves on NCQA's Data Submission Tool (DST) Development Workgroup, which has a current goal of converting the DST to an entirely web-based program.

Previous Experience

HSAG, Phoenix, Arizona: Associate Director, EQRO Services (06/07–present); Senior Director, Statistical Evaluation (3/06–5/07); Director, State & Corporate Analysis (11/02–02/06); Director, Applied Statistics (10/02–6/00); Statistical Analyst (11/93–12/99); 11/93–Present

Consultant/Tutor, Phoenix, Arizona: 8/92–12/96

The Huntington Learning Center, Mesa, Arizona: Head of the Mathematics Department; 1/91–6/92

Education

MS Applied Statistics, Decision and Information Systems, Arizona State University, Tempe, Arizona, 12/96

BA Mathematics, University of Texas, Arlington, Texas, 12/90

Associate Arts and Sciences, Eastfield College, Mesquite, Texas, 12/87

Technical Experience

Statistical Packages: SAS and STATA

Computers: BASIC, PASCAL, and FORTRAN

Software: Excel, Lotus 123, Freelance, Windows, Word, WordPerfect, PowerPoint, Lindo and various other software packages

Certifications, Professional Organizations, and Publications

NCQA-Certified HEDIS® Compliance Auditor (CHCA), 1/99–Present

NCQA Data Submission Tool (DST) Development Workgroup, Member

Arizona State University

Greeting to all to whom these Letters shall come
The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

David Daniel Mabb

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Master of Science

with all the Rights, Privileges and Honors thereunto appertaining
In Witness whereof the Seal of the University is hereto affixed
Awarded at the Main Campus
this twentieth day of December, one thousand nine hundred and ninety-six.

Governor of Arizona

President of the Board

ARIZONA STATE UNIVERSITY · 1885 ·

President of the University

Sr. Vice President and Provost

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

David Mabb

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2010	10/31/2012
DATE CERTIFIED	EXPIRATION DATE

Joseph Tenison, MBA
HEDIS Auditor, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6838
jotenison@hsag.com

Qualification Highlights

During his nine years with Health Services Advisory Group, Inc. (HSAG), Mr. Tenison has held progressively responsible positions within the areas of operations and finance. He holds an MBA from W.P. Carey School of Business, Arizona State University.

Relevant Experience in the State and Local Government Sector

HSAG, Auditor—HEDIS, Performance Measure Validation, State & Corporate Services: Mr. Tenison is responsible for general audit-related activities including implementation, project management, analysis, reporting, orientation and training. Additionally, he is responsible for assisting lead auditors with pre-on-site, on-site and post-on-site activities for HSAG's Healthcare Effectiveness Data and Information Set (HEDIS) and External Quality Review Organization (EQRO) contracts.

HSAG, Project Accountant: As a Project Accountant, he maintained and developed budget templates, priced contracts, maintained multiple accounts for Health Services Holdings, Inc. (HSH), and subsidiary companies, allocated accounting pools, and maintained regular financial reporting.

HSAG, Accounts Payable Specialist: Mr. Tenison entered all invoices and developed MS Excel tools and expense reports. He was responsible for correcting expense reports to cohere with federal guidelines and training employees on proper reporting guidelines.

HSAG, Project Specialist: Mr. Tenison supervised the Facilities Department, maintained companywide meeting schedules, planned and developed office suites for relocation of HSAG corporate offices, and managed relationships with vendors.

Previous Experience

HSAG, Phoenix, Arizona: HEDIS Auditor, State & Corporate Services (11/11–Present); Project Accountant (9/09–11/11); Accounts Payable Specialist (11/08–9/09); Project Specialist (9/05–6/07); Associate Facilities Manager (6/05–9/05); Facilities Maintenance (5/03–6/05); 5/03–present

Dickinson Architects, Phoenix, AZ: Project Manager; 11/07–08/08

Design Drywall West, Tempe, AZ: Project Estimator; 06/07–11/07

Phoenix Design One, Tempe, AZ: Intern; 06/05–11/05

Education

MBA, W.P. Carey School of Business, Arizona State University, Phoenix, AZ, 2011

BA, Architecture, Arizona State University, Tempe, Arizona, 2007

Certifications, Professional Organizations, and Publications

Construction, ASTM 143 Certified

Arizona State University

The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Joseph Laurence Tenison

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Master of Business Administration

in the

W. P. Carey School of Business

with all the Rights, Privileges and Honors thereunto appertaining
this twelfth day of May, two thousand and eleven.

Governor of Arizona

Chair of the Board

President of the University

Christi L. Melendez, RN, CPHQ
Project Manager, PIPs

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6875
cmelendez@hsag.com

Qualification Highlights

Ms. Melendez has more than 20 years experience as a Registered Nurse in the clinical and home health settings, including case management and medical record reviews. In her previous role as Project Leader, PIP Team, she worked closely with the Project Manager, PIP Team, to validate health plan performance improvement projects.

As an RN Abstractor/Coordinator at HSAG, Ms. Melendez worked on a variety of projects including the RAND Cost of Cancer Treatment Study (CCTS). She also assisted in the training of other RN abstractors, and provided on-site medical reviews for HEDIS auditing.

Ms. Melendez recently became a Certified Professional in Healthcare Quality (CPHQ) by Healthcare Quality Certification Board.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Manager, PIP Team: As a Project Manager for the PIP Team, Ms. Melendez oversees the PIP Review Team staff and develops in-service training for the Team. She provides technical assistance to health plans throughout their PIP process, including creating presentations to train states about the PIP process. She assisted in the writing of the PIP Reviewer's Guide and the MCO guides for the PIP process. Working closely with the Executive Director, State & Corporate Services, Ms. Melendez performs validation of physical and behavioral health PIPs. She also writes PIP Validation reports, explaining the validity and reliability of the PIP findings. In addition, she is involved in writing PIP Annual Summary Reports and EQRO Technical Reports.

As a **PIP Reviewer II**, Ms. Melendez performed validation of physical and behavioral health PIPs by assessing the implications on the validity and reliability of the PIP findings and was responsible for providing technical assistance to States as needed.

As a **Review Coordinator/Abstractor**, Ms. Melendez performed review and abstraction of medical records to assess quality of care, practice guidelines, variation in care and outcome, and to substantiate review findings.

Banner Home Health, Case Manager: Case management of pregnant and pediatric patients, adult home health patients, infusing patients, coordinating the care with a multidisciplinary team, and student nurse and new employee preceptor duties. Performed chart audits for multiple teams, including Medicare/Medicaid.

Gentiva Health Services, Manager of Clinical Practice: Case management of long-term, chronically ill children. Prepared quality assurance and treatment plans as well as performed medical record/documentation audits. Participated as a member of the Performance Improvement Committee.

I.H.S. Home Care, Senior Case Manager: Case management of pregnant and pediatric patients, coordinating the care with a multidisciplinary team. Performance Improvement Coordinator for the pediatric team. Performed chart audits for multiple teams, including Medicare/Medicaid.

Previous Experience

HSAG, Phoenix, Arizona: EQRO Project Manager, PIP Team (10/08–Present), Project Leader, PIP Team (1/07–10/08), PIP Reviewer II (1/06–1/07), Review Coordinator/Abstractor (2001–1/06); 2001-Present

Banner Home Health, Case Manager; 2004–2007

Centrum Health Care, Pediatric Field Nurse; 2002–2004

Gentiva Health Services, Manager of Clinical Practice; 1999–2000

Children's Home Care, Intermittent Visit Nurse; 3/99–12/99

I.H.S. Home Care, Senior Case Manager; 1991–1999

Desert Samaritan Medical Center, Staff RN; 1990–1991

Whittier Presbyterian Hospital, Staff RN; 1986–1989

Education

Associate of Science, Nursing, Cypress College, Cypress, California, 1986

Certifications, Professional Organizations, and Publications

Certified Professional HealthCare Quality by Healthcare Quality Certification Board, 2009

(CUT HERE)

ARIZONA STATE BOARD OF NURSING
4747 N. Seventh Street, Suite 200
Phoenix, AZ 85014-3655
(602) 771-7800

RN RENEWAL

License issued to

(CUT HERE)

MELENDEZ, CHRISTI
[redacted]

Signature:

RENEWAL DUE DATE	LICENSE NO.
04/01/2015	[redacted]

(CUT HERE)

Practi
renew

ADDI
and p

NAMI
your r
if you
curre
fee, g

LOST

MULT

Phon
E-mai

Healthcare Quality Certification Board

This Certifies That

Christi Lea Melendez

Having met the standards established by the Healthcare Quality Certification Board and passed the written examination has attained the designation of

Certified Professional in Healthcare Quality

On August 28, 2009

Accredited by the National Commission for Certifying Agencies. A Division of The National Organization for Competency Assurance

Certified through 12/31/2011

Chair of the Board of Directors

CPHQ No [redacted]

Christy Hormann, MSW, CPHQ
EQRO Project Leader, PIP Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6836
chormann@hsag.com

Qualification Highlights

Ms. Hormann has more than seven years of health care related experience in a variety of settings. She holds a Master's of Social Work (MSW) from Arizona State University. Ms. Hormann is a skilled case manager and chart reviewer. She has also been responsible for patient satisfaction surveys and the development and implementation of performance improvement measures.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), EQRO Project Leader, PIP Team: Performs validation of physical and behavioral health PIPs by assessing the implications on the validity and reliability of the PIP findings. She is responsible for providing technical assistance and training to States as needed.

Independent Case Review Project Coordinator, State and Corporate: In her previous position, Ms. Hormann was a Project Coordinator for the State & Corporate Services, providing day-to-day oversight and management of data abstraction staff. She also performed reviews of behavioral health records, including data abstraction on the 2002 and 2003 ADHS ICR project. Her role as Project Coordinator included the recruitment, selection, orientation, training, and ongoing quality oversight of HSAG's behavioral health record abstractors.

Ms. Hormann's additional responsibilities at HSAG include validating physical and mental health performance improvement projects, assisting in tool development and report preparation as well as providing technical guidance on how to conduct performance improvement projects.

Ms. Hormann has also completed medical necessity review as well as face-to-face interviews with TXIX and TXXI members, under the age of 21, receiving behavioral health services through the State of Arizona.

Renal Care Group, Social Worker: While in this position, Ms. Hormann performed quarterly chart reviews, as well as assessment, referral and coordination of patient services. Ms. Hormann was responsible for the distribution and tracking of annual patient satisfaction surveys for yearly performance measures. Upon completion of the yearly performance

measures, she analyzed and implemented performance improvement projects.

Arizona DES, Child Protective Services Specialist III: As a CPSS III, Ms. Hormann performed case management of children and families and utilization review. She also prepared and presented individual cases to the Foster Care Review Board.

Previous Experience

HSAG, Phoenix, Arizona: EQRO Project Leader, PIP Team (10/06–present); Project Coordinator for ICR Project, State and Corporate: (1/05–10/06); Behavioral Health Abstraction Pool, State and Corporate: (2002–2005); 2002–present

Renal Care Group, Phoenix, Arizona: Social Worker; 2002–2005

Arizona DES, Phoenix, Arizona: Child Protective Services Specialist III; 2000–2002

Paradise Valley Hospital, Phoenix, Arizona: Social Worker; 1999–2000

Sutton Homes, Phoenix, Arizona: Care Director; 1997–1999

Education

Master of Social Work, Arizona State University, 2000

Bachelor of Science in Social Work, with a minor in Psychology, St. Cloud State University, 1996

Certifications, Professional Organizations, and Publications

Certified Professional HealthCare Quality by Healthcare Quality Certification Board, 2009

State of Arizona
Board of Behavioral Health Examiners

Be It Known That

Christy M. Hormann

Having exhibited to the Board of Behavioral Health Examiners satisfactory evidence of having met requirements to practice as prescribed by law, is hereby licensed as a

Licensed Master Social Worker

The Arizona Board of Behavioral Health Examiners hereby grants this

License Number [redacted]

Under its seal and signatures,

Laura de Blank
Board Chair

Issue Date: October 1, 2011
Expiration Date: September 30, 2013

Healthcare Quality Certification Board

This Certifies That

Christy M. Hormann

Having met the standards established by the Healthcare Quality Certification Board and passed the written examination has attained the designation of

Certified Professional in Healthcare Quality

On February 19, 2009

Accredited by the National Commission for Certifying Agencies. A Division of The National Organization for Competency Assurance

Certified through 12/31/2011

Chair of the Board of Directors

CPHQ No [redacted]

Kate Bell, MA
PIP Reviewer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6876
kbell@hsag.com

Qualification Highlights

Ms. Bell's knowledge of scientific soundness of study design, statistical analysis, and interpretation help her serve as a technical resource for the analysis of quality of care or service studies. She coordinates performance improvement projects (PIPs) across all stages, including submission, validation and report writing. She is responsible for editing content, reviewing technical documentation and merging data from multiple sources for the PIP Team. Ms. Bell is adept at analyzing and interpreting complex documents. She excels at accurately editing, organizing and presenting information.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), PIP Reviewer: Ms. Bell reviews and evaluates health care quality improvement projects and provides input for continued improvement. She has experience in the design, implementation, analysis, evaluation, and reporting of health care quality improvement projects. She coordinates and participates in data abstraction, data collection, data comparison and deliverable monitoring. She has the ability to train others on quality improvement protocols. She coordinates PIP Team activities, develops opportunities for improvement, edits complex documents and creates presentations. Ms. Bell tracks PIP submissions, researches historical documents and reviews draft documentation to ensure data completeness.

Southwest Ambulance, Office Administrator/Executive Assistant: At Southwest Ambulance, Ms. Bell served as the main point of contact for joint Southwest Ambulance—Rural/Metro functions. She was responsible for maintaining open lines of communication between c-level executive staff, field employees and stakeholders. Her duties included responding to sensitive requests, creating and presenting complex documents, conducting legal research and responding to c-level executive needs. Her accomplishments include reducing overhead by consolidating job duties and developing beneficial long-term relationships with vendors and stakeholders.

Empowerment Systems, Inc., Chief Administrative Officer: As CAO for Empowerment Systems, Inc., Ms. Bell developed an award-winning Web site, created a nationally released press release, co-authored a winning proposal for a $500k/year contract, established a community partnership program and helped implement health care software

applications. Her responsibilities included contract negotiation, workforce development, staff supervision and training, project management and company Web site maintenance.

Pinal Gila Behavioral Health Association, Program Compliance Coordinator/Grievance & Appeals Administrator: Ms. Bell has extensive experience with diverse behavioral health populations, including long term care, in a managed care setting. She has extensive knowledge of state and federal health care regulations. Ms. Bell developed and published a quarterly provider profile, successfully processed grievances and appeals per State requirements developed a grievance and appeal notice monitoring process, and coordinated the accreditation process/activities for TJC (formerly JCAHO). She was responsible for monitoring and coordinating provider quality management activities, administering the grievance and appeals program, and developing and presenting complex documents. Ms. Bell also provided training and technical assistance to staff and providers. At the request of her employer, she successfully completed her paralegal certification.

Previous Experience

HSAG, Phoenix, Arizona: PIP Reviewer, (2/12–present); Project Coordinator, PIPs (12/11–1/12); 12/11-Present

Southwest Ambulance, Mesa, AZ: Office Administrator/ Executive Assistant to Rural/Metro Corp. Executive Vice President/Chief Operating Officer, Executive Assistant to Southwest Ambulance Southwest Zone Vice President; 11/09–12/11

Empowerment Systems, Inc., Apache Junction, Arizona: Chief Administrative Officer; 2006–2009

Pinal Gila Behavioral Health Association, Apache Junction, Arizona: Program Compliance Coordinator/Grievance & Appeals Administrator; 2001–2005

MassMutual, Scottsdale, Arizona: Coordinator—Technology Consulting Group; 1999–2001

KETRON, Lexington Park, Maryland: Analyst; 1997–1999

Education

MA, Organizational Management, University of Phoenix, Arizona

BA, Communications, Virginia Polytechnic Institute and State University (Virginia Tech), Blacksburg, VA

Technical Experience

MS Word, Excel, PowerPoint

Certifications, Professional Organizations, and

Paralegal Certification, Washington Online Learning Institute, Nanuet, New York

Publications

Certified Quality Management Professional, Learning Tree University, California

Notary Public, State of Arizona

Security Clearance, Department of Defense - Secret

University of Phoenix

Upon the recommendation of the Faculty,
the University of Phoenix does hereby confer upon

Kathryn L. Bell

The Degree of

Master of Arts in Organizational Management

with all the rights, honors and privileges thereunto appertaining.

In witness whereof, the seal of the University and the signatures as authorized
by the Board of Directors, University of Phoenix, are hereunto affixed,
this thirty-first day of August, in the year two thousand and one.

Chairman, Board of Directors

UNIVERSITY OF PHOENIX

President

LTU Extension

Upon recommendation of the Faculty and by virtue of the Authority vested by the State of California does hereby certify that

Kate Bell

has earned with distinction the certificate in

Quality Management

with all rights, privileges and honors appertaining thereto.

September 7, 2002

Christy Wilson
Vice President Academic Affairs

Learning Tree University
Established 1974
California

B. Michael Gould
President

The Washington Online Learning Institute

Kathryn Bell

has completed the courses prescribed for the distinguished award of

Certificate of Paralegal Studies

(528 Hours)

In testimony whereof, the Board of Directors of the Washington Online Learning Institute has caused this Certificate to be issued, under the Corporate Seal of the Institute at Nanuet, New York, this, the 20th day of July, 2005 A. D.

SEAL

Michael A. Kopko
School Director

Academic Director

LITHO. IN U.S.A.

LTU

EXTENSION

Department of Continuing
Nursing Education
20960 Knapp Street
Chatsworth
California
91311

Certification of Completion

This is to certify that

Kate Bell

License Number

has successfully completed the course

Critical Issues In Qm

for a total of 8.0 contact hours.

September 7, 2002
Date(s) of Attendance

Phoenix, AZ
City and State

June Devine
Continuing Nursing Education Director

LTU Extension is approved as a provider of Continuing Nursing Education by the Colorado Nurses Association, which is accredited as an approver of CNE by the American Nurses Credentialing Center's Commission on Accreditation.
Provider approved by the California Board of Registered Nurses, BRN Provider #10293.
This certificate must be retained by the licensee for four years after the completion of the course.

EOL/PH

LTU

EXTENSION

Department of Continuing
Nursing Education
20960 Knapp Street
Chatsworth
California
91311

Certification of Completion

This is to certify that

Kate Bell

License Number

has successfully completed the course

The Quality Improvement Process

for a total of 8.0 contact hours.

September 5, 2002
Date(s) of Attendance

Phoenix, AZ
City and State

June Devine
Continuing Nursing Education Director

LTU Extension is approved as a provider of Continuing Nursing Education by the Colorado Nurses Association, which is accredited as an approver of CNE by the American Nurses Credentialing Center's Commission on Accreditation.
Provider approved by the California Board of Registered Nurses, BRN Provider #10293.
This certificate must be retained by the licensee for four years after the completion of the course.

EOL/PH

LTU

EXTENSION

Department of Continuing
Nursing Education
20916 Knapp Street
Chatsworth
California
91311

Certification of Completion

This is to certify that

Kate Bell

License Number

has successfully completed the course

Tools For Analysis And Trending In Qi

for a total of 8.0 contact hours.

September 6, 2002
Date(s) of Attendance

Phoenix, AZ
City and State

June Devine
Continuing Nursing Education Director

This EDI activity for 24 contact hours is approved by the Colorado Nurses Association, which is accredited as an approver of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.
Provider approved by the California Board of Registered Nurses, BRN Provider #10293.
This certificate must be retained by the licensee for four years after the completion of the course.

Donald Grostic, MS
Associate Director, Research Analysis Team (RAT)

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6863
dgrostic@hsag.com

Qualification Highlights

Mr. Grostic has more than 15 years experience in health care-related data analysis, statistical reporting, and database management in the managed care environment. He has experience with quality of care studies, utilization analysis and reporting, and HEDIS measures. He holds a Bachelor of Science degree in Mathematics and a Master of Science in Biostatistics, both from the University of Vermont.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Associate Director, Research Analysis Team: Provides research leadership, analytical expertise, technical interpretive writing and mentoring. Responsible for the scientific soundness of study design, analysis and interpretation of a variety of health care studies. Studies include, but are not limited to, analysis of CAHPS and other health care surveys, HEDIS, EPSDT, network adequacy, encounter data validation, and quality of care studies. Also responsible for reviewing and approving the work of healthcare analysts.

Banner Health, **Manager Clinical Data:** Responsible for the oversight of Pre-client data analysis, Provider Radiology Profile Reports, sampling methodology for provider and patient satisfaction surveys, and the development and analysis of Quality Assurance Department quality and focus studies for a radiology management services organization. Accountable for production and accuracy of clinical practice guideline reports, trend factor methodology, re-insurance analysis, claims edit process and statistical audit methodology. Developed, organized and presented quality studies, utilization reports, statistical reports and methodology to senior staff and contracted clients.

- Oversight and development of a tracking database to manage the Pre-engagement data analysis, which includes the calculation of UR/1000, PMPMs, Total cost by Modality, Total cost by Line of Business and Mis-match procedures.
- Developed a statistical methodology to measure compliance by referring physician for clinical practice guidelines for the Cigna Dallas contract.
- Compiled an exploratory quality study on deep vein thrombosis (DVT), pulmonary embolism (PE) and cardiac embolism (CARD). The study

for Berlex Laboratories compared the standard population's claims of a New England HMO to the subset population specifically diagnosed with PE/DVT/CARD.

- Analyze client claims data to develop benchmarks and opportunities for educational efforts.
- Supports QM/UM regional committee activities with required ad hoc reports.

Cigna Healthcare, Manager, Medical Economics: Responsible for the oversight of commercial monthly and annual medical expense and variance analysis, and measurement methodology of medical action planning. Accountable for the production and accuracy of medical cost, quality, and utilization analysis and reporting. Developed, designed and maintained process and outcome metrics to monitor performance and forecast future results, organized and presented utilization reports, statistical reports and methodology to senior staff.

- Developed reporting methodology for extraction of detail data to support Primary Care Physician interventional efforts by Medical Directors.
- Compiled an exploratory study of professional costs on immunizations and injections. The study led to an identification of specific immunizations (Prevnar) driving PMPM increases.
- Oversight for the production of monthly key metrics (e.g., bed days/1000) inputs to medical forecasting.
- Oversight of detailed cost and utilization analysis identifying key drivers at sufficient detail to focus appropriate risk management interventions (e.g., at service and provider level detail).

Previous Experience

HSAG, Phoenix, Arizona: Associate Director, Research Analysis Team (12/06–Present), Senior Healthcare Analyst; (2/06–11/06); 2/06–Present

Bikram Yoga Paradise Valley, Phoenix, Arizona: Independent Contractor – Director - Operations; 2005–2006

Banner Health, Phoenix, Arizona: Manager Clinical Data; 2003–2004

Cigna Healthcare, Phoenix, Arizona: Manager, Medical Economics; 2001–2002

Healthhelp, Inc., Phoenix, Arizona: Director, Clinical Data Analysis; 2001–2001

TRIWEST Healthcare Alliance, Phoenix, Arizona: Manager, Clinical Data Analysis (1998–2001); Senior Health Information and Reporting Analyst (1997–1998); 1997–2001

	FHP, Inc., Phoenix Arizona: Medical Information Support Manager (1995-1997); Medical Biostatistician (1993-1995); 1993-1997
Education	Master of Science in Biostatistics, University of Vermont, Burlington Vermont, 1993 Bachelor of Science in Mathematics, University of Vermont, Burlington, Vermont, 1991
Technical Expertise	SPSS, Microsoft Word, PowerPoint, Excel, Access, Project, Outlook, Visio, McKessonHBOC CRMS 4.0, QMF/TSO, SQL, claims data and systems, regression, modeling, time series forecasting, survey sampling, outcome study design and project management and facilitation.

The University of Vermont

Know all by these presents that

Donald Patrick Grostic

has been admitted to the degree of

Master of Science

and to all the honors, rights, privileges and obligations pertaining to that degree.
In Testimony Whereof, this diploma is conferred at Burlington,
Vermont, this twenty-second day of May, 1993.

Secretary of the Board of Trustees

Dean

President of the University

Jennifer Montano
Project Coordinator, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6851
jmontano@hsag.com

Qualification Highlights

Ms. Montano has extensive experience providing administrative support and project coordination in the health care field. She brings excellent communication, organizational, and interpersonal skills and is self-motivated, efficient, and reliable under pressure. Ms. Montano is detail oriented in completing tasks and has the ability to multi-task effectively. She consistently goes beyond what is required. At HSAG, Ms. Montano supports several external quality review organization (EQRO) contracts and the Communications Department, and she oversees the corporate Xerox account.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Coordinator, State & Corporate Services: As a Project Coordinator for the State & Corporate Services, Ms. Montano is responsible for providing day-to-day project coordination and administrative support to the Executive Director and the Project Director for EQRO contracts for states that include Florida, Nevada, and Tennessee. She is responsible for compliance review database assistance, report production and formatting, file transfer protocol (FTP) site maintenance, timeline monitoring, meeting coordination, travel scheduling in multiple time zones, and other duties as assigned. Ms. Montano also assists the request for proposal (RFP) team as needed.

In addition to her support of the State and Corporate Services department, Ms. Montano also supports the Corporate Communications team at HSAG. She is responsible for creating, producing and maintaining corporate marketing materials, business cards and corporate stationary for all HSAG office locations. She creates and edits flyers, posters, ads, report covers and brochures as requested. Ms. Montano provides Federal Division administrative support to the Director, Health Education & Publications, Director, Health Communications as well as the Communications Project Manager as needed.

Ms. Montano also oversees the corporate Xerox account for all HSAG locations, including FMQAI in Tampa. Her responsibilities include maintaining an effective working relationship with the Xerox Account Manager as well as the Xerox Account Associate in the Phoenix office. She monitors and coordinates Xerox contract activities, which include new equipment purchases, equipment updates, equipment moves, off-site

production assistance, and staff coverage. She is also responsible for monthly invoice reconciliation and account job coding for the production center in Phoenix. Ms. Montano works as a liaison between Xerox administrative staff and HSAG executive staff.

Previous Experience

HSAG, Phoenix, Arizona: Project Coordinator, State & Corporate Services (6/09–Present); Administrative Assistant I/II/III, Communications & Administration (2/96–6/09); Staff Secretary I/II, Federal Case Review (10/93–2/96); Medical Records File Clerk, Federal Case Review (5/91–10/93); 5/91–Present

Terry Campbell & Associates, Phoenix, Arizona, Assistant/Tax Preparer: 6/89–5/91

Technical Experience

Proficient in Microsoft Office 2010 (Outlook, Word, PowerPoint, Excel, Access), Adobe Acrobat 9 Professional, Adobe InDesign 5

Diane Christensen, MC, LPC
Director, State & Corporate Services

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6833
dchristensen@hsag.com

Qualification Highlights

Ms. Christensen has over 20 years of senior leadership experience in healthcare management, Medicaid managed care, and quality improvement. She has provided regulatory analysis and compliance monitoring in a variety of public and private physical and behavioral healthcare settings.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Director State and Corporate Services: As a director in the State & Corporate Services, she is responsible for leading or serving as a resource for designated State and Corporate Services' projects and acts as a contract liaison and directs EQRO activities for several states for which HSAG is the EQRO. Activities include staff training and development for EQR activities; development and quality control of review tools; management of assigned EQR projects/state contracts related to scope of work, budgets, and staffing; and leading or participating in compliance audits of Medicaid managed care organizations.

Arizona Health Care Cost Containment System (AHCCCS), Administrative Officer III, Office of Managed Care: Directed the activities of the behavioral health clinical unit and supervised the program clinical analysts for the Arizona State Medicaid agency, AHCCCS. Monitored and evaluated the quality of behavioral health services provided to Medicaid enrolled individuals through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and through the contracted Acute Care and Arizona Long Term Care contractors. Performed analysis and interpretation of federal and State regulations, statutes, and agency policies impacting Medicaid behavioral health services and prepared briefing and position papers. Provided leadership to agency and community task forces, forums, committees, and policy groups in assessing behavioral health service needs, program development, and in developing performance and quality of care standards.

CIGNA Healthcare, Assistant Director/Policy Oversight: Provided leadership to eight field sites responsible for all 50 states in interpreting, implementing, and complying with commercial insurance regulations. Designed a compliance appraisal tool that assessed field operations baseline infrastructure and compliance. Prepared compliance and improvement action plans that established division strategic direction and critical path actions to strengthen performance. Enhanced quality and effectiveness of information flow between legal/compliance departments and the field operating sites. Established organizational infrastructure and developed management tools (i.e., on-line communication and workflow tracking record, web site template as a real time repository for regulatory requirements, and internal audit template). Provided technical assistance, training, and consultation to the field.

CIGNA Healthcare. Paseo Healthcare Center Manager: Managed the operations of a large multi-specialty, staff model ambulatory health care center providing services to commercial and Medicare patients, including responsibility for financial, quality, customer satisfaction, and work environment operations and performance accountabilities. Implemented process and performance improvement action plans targeting performance that fell below targets. Center performance improved on all key corporate drivers (quality, financial, customer satisfaction and work environment). Center departments included family practice/internal medicine, obstetrics/gynecology, radiology, pharmacy, urgent care (24 hour), medical records, and administration.

ComCare, Inc./CODAMA, Director of Quality Management, Utilization Review, Grievance and Appeal System & Risk Management: Managed and responsible for performance accountabilities for the QM (quality improvement, internal & network training, licensure and compliance, and medical records), Utilization Management, Grievance/Appeals and Risk Management Departments. Implemented collaborative problem solving strategies that resulted in enhanced relationships with state funding sources and reduced the number of overturned patient appeal decisions. Initiated an intra/inter department supervisor leadership training and development program that enhanced leadership skills and technical and process management competencies.

Previous Experience

HSAG, Phoenix, Arizona: Associate Director, EQRO Services, Project Manager. Associate Director, and Director State and Corporate Services positions; 9/04–Present

AHCCCS, Phoenix, Arizona: Clinical Coordinator, Behavioral Health Unit; 2001–2004

CIGNA Healthcare, Arizona: Assistant Director/Policy Oversight; 2000–2001

CIGNA Healthcare, Arizona**:** Paseo HealthCare Center Manager; 1998–2000

ComCare, Inc./CODAMA, Phoenix, Arizona: Director of QM, UR, G/A & RM (1997–1998); Director of Clinical Operations (1994–1997); Director of Clinical Services (1991–1994); Director of Program/Network Management (1985–1991); 1980–1998

Education

Masters of Counseling, Arizona State University, Tempe, Arizona, 1972

Bachelor of Science Secondary Education (English/Speech), West Virginia University, Morgantown, West Virginia, 1965

Certifications, Professional Organizations, and Publications

Licensed Professional Counselor, Arizona Board of Behavioral Health Examiners

Arizona State University

Greeting to all to whom these Letters shall come

The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Diane Jenkins Herod

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Master of Counseling

with all the Rights, Privileges and Honors thereunto appertaining

In witness whereof the Seal of the University is hereto affixed
Done at Tempe, Arizona, this fifteenth day of September, in the
year of our Lord one thousand nine hundred and seventy-two

ARIZONA STATE UNIVERSITY · GREAT SEAL OF THE STATE OF ARIZONA · DITAT DEUS · 1912 · 1885 ·

Paul L. Singer M.D.
President of the Board

Secretary of the Board

Jack Williams
Governor of Arizona

President of the University

Registrar of the University

State of Arizona
Board of Behavioral Health Examiners

Be It Known That

Diane Christensen

Having exhibited to the Board of Behavioral Health Examiners satisfactory evidence of having met requirements to practice as prescribed by law, is hereby licensed as a

Licensed Professional Counselor

The Arizona Board of Behavioral Health Examiners hereby grants this

License Number [redacted]

Under its seal and signatures,

Laura de Blank
Board Chair

Issue Date: July 1, 2004
Expiration Date: September 30, 2013

Barbara J. McConnell, MBA, OTR
Project Director

Personal Information

Health Services Advisory Group, Inc.
3025 South Parker Road, Suite 722
Aurora, Colorado 80014
303.755.1912
bmcconnell@hsag.com

Qualification Highlights

Ms. McConnell is a registered occupational therapist with over 20 years of experience in a variety of health care settings, including mental health centers, hospitals, and rehabilitation centers. She also brings a thorough knowledge of the start-up and ongoing management of rehabilitative facilities, from development of collaboratives in the community, working with funding sources such as Medicare and Medicaid, and coordinating care plan programs with ongoing case management and quality improvement/assurance.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Director: Based in HSAG's Aurora, Colorado Project Office, Ms. McConnell is responsible for the day-to-day oversight of activities for HSAG's Colorado EQRO contracts. She is the primary point of contact with the Department of Health Care Policy and Financing, and participates in meetings with the Department, as well as leading the compliance monitoring team activities.

As **Project Manager** for HSAG, Ms. McConnell was responsible for reviewing desk audit materials, on-site audit activities, and preparation of the report of audit findings for HSAG's Colorado and Utah Mental Health EQRO contracts. As **Project Leader**, she was responsible for analyzing and evaluating pertinent information for mental health organization on-site reviews, and coordinating various contract activities and deliverables.

Compliance Reviewer: Participates as part of the team for on-site medical record reviews, including review of organizational standards and compliance. Provides client feedback and reports on review findings in follow-up to site visits. Assists the project team with accurate and supportive recommendations.

Metro Region of Carmel Community Living Corporation, Region Manager: Responsible for the development of region for human service agency (Medicaid waiver funded) entering a new market at that time.

- Took the region from startup to $1.8 million annual budget
- Developed and managed contract with four Community Centered Boards in the Metro area
- Negotiated contracted rates for each new individual served

- Developed budget and managed profit/loss
- Developed programs in residential, supported living, vocational and day treatment.
- Managed department heads in Medical, Operations, Program/QA, and Finance
- Took the region from 2 regional level employees (including self) supervising approximately 10 direct care staff, to an operation of 18 regional, management level employees with over 100 direct care staff/providers

Mariner Post-Acute Network/Prism Rehab Systems, Program Manager:

- Provided support for both the long-term care and the skilled nursing facilities
- Served as Acting Administrator in Administrator's absence for one facility
- Had operational and financial responsibility for five Departments (Occupational Therapy, Physical Therapy, Speech/Language Pathology, Respiratory Therapy, Restorative Nursing) for both facilities
- Recruited and hired personnel for two buildings (within departmental responsibility)
- Developed programs and implemented of interdisciplinary committees/programs; Completed CQI Projects and served on related committees for both facilities
- Performed case management for Medicare and Managed Care patients
- Led Marketing Committee; created marketing flyers/materials
- Coordinated MDS/Care Plan, including transmittal and coordination with the State
- Chaired JCAHO preparation committee
- Performed Prospective Payment System/Balanced Budget Act tracking

South Coast Rehabilitation Services, Area Manager of Operations (Missouri and Colorado):

- Provided interdisciplinary management (OT, PT, SLP) for national contract company providing rehabilitation services
- Managed marketing and new contract roll out
- Served as liaison between corporate office and clinical management
- Provided oversight of program development
- Maintained quality assurance and fiscal responsibility for 2 states, 12 buildings

Previous Experience

HSAG, Denver, Colorado: Project Director (01/07–present); Project Manager (11/06–12/06); Project Leader (07/05–10/06); 07/05–Present

Metro Region of Carmel Community Living Corporation, Englewood, Colorado: Region Manager, 10/99–6/04

Mariner Post-Acute Network/Prism Rehab Systems, Aurora and Commerce City, Colorado: Program Manager, 6/96–8/99

South Coast Rehabilitation Services, Laguna Hills, California: Area Manager of Operations (Missouri and Colorado), 10/94–6/96

Rockhurst University, Kansas City, Missouri: Academic Fieldwork Coordinator and Instructor of Occupational Therapy; 1/91–10/94

CPC College Meadows Hospital, Lenexa, Kansas: Director, Rehabilitation Therapies; 1/90–1/91

Swope Ridge Geriatric Center, Kansas City, Missouri: Director, Rehabilitation Services; 8/88–1/90

Consultant for several Residential Treatment Centers:

- **CPC College Meadows Hospital**, Lenexa, Kansas: Consultant, 1988–1993
- **Marillac Center for Children**, Kansas City, Missouri: Consultant; 1988–1993
- **Gemini Village**, Kansas City, Missouri: Consultant; 1988–1993

University of Kansas, Lawrence, Kansas: Graduate Teaching Assistant, 1/88–7/88

Western Missouri Mental Health Center, Kansas City, Missouri: Occupational Therapist, 10/85–8/87

Research Medical Center, Kansas City, Missouri: Occupational Therapist; 1979–1985

Johnson County Mental Health Center, Olathe, Kansas: Occupational Therapist; 1979–1985

Education

Master of Business Administration, University of Kansas, Lawrence, Kansas, 1988

Bachelor of Science, Occupational Therapy, Ohio State University, Columbus, Ohio, 1979

Certifications, Professional Organizations, and Publications

American Occupational Therapy Certification Board – OTR

The Ohio State University

hereby confers upon

Barbara Jean Ackman

the degree of

Bachelor of Science in Allied Health Professions

together with all the rights, privileges and honors appertaining thereto in consideration of the satisfactory completion of the course prescribed in

The School of Allied Medical Professions - The College of Medicine

In Testimony Whereof, the seal of the University and the signatures as authorized by the Board of Trustees are hereunto affixed.

Given at Columbus on the seventh day of December, in the year of our Lord nineteen hundred seventy-nine and of the University the one hundred and tenth.

THE OHIO STATE UNIVERSITY 18 70 DISCIPLINA IN CIVILEM COLUMBUS

Patricia D. James
Chairman of the Board of Trustees

Harold L. Enarson
President of the University

Madison H. Sears
Secretary of the Board of Trustees

The American Occupational Therapy Association

certifies that

Barbara Jean Ackman

having fulfilled the requirements—has been duly enrolled as an

Occupational Therapist, Registered

in the national register maintained by this association and is therefore entitled

to use the designating initials

O.T.R.

James J. Gaudiosi
Executive Director

Mae D. Highsmith-Vandamm
President

Registration Number [redacted]

Date February 2, 1980

The University of Kansas

By the authority of the Board of Regents of the State of Kansas and
upon the recommendation of the Faculty of the

Graduate School

confers upon

Barbara Jean McConnell

the degree of

Master of Business Administration

with all its rights, privileges, and responsibilities.
Given under the seal of the University of Kansas
this seventeenth day of October, nineteen hundred and eighty-eight.

State Board of Regents

Richard W. Dodderidge
Chairman

Norman W. Bradshaw

Robert B. Creighton

Norman W. Feller

Shirley J. Palmer

Richard P. Smith

Linwood B. Upton

Gene A. Budig
Chancellor

Judith A. Ramaley
Executive Vice Chancellor

Frances Degen Horowitz
Dean

A. W. Warren
Dean of Educational Services

Thomas D. Miller, MA
Executive Director, Research and Analysis Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6860
tmiller@hsag.com

Qualification Highlights

Mr. Miller has more than 10 years of experience performing statistical analysis in a health care setting, including Medicaid managed care, pharmacy benefit management, disease management, and claims processing. He has extensive experience managing retrospective and survey research studies and encounter data validation studies involving the coordination of internal and external customers. Mr. Miller has worked with NCQA/QISMIC accreditation standards and HEDIS performance measures (including work with CAHPS). He has performed highly technical data manipulation/analysis to render meaningful interpretations and to translate quantitative and qualitative research into operational goals, standards, and improvement activities.

As Executive Director of the Research and Analysis Team at HSAG, Mr. Miller provides research leadership, analytical expertise, technical interpretive writing, and mentoring for the State & Corporate Services analytical staff. He has been involved in designing and executing numerous focused studies including evaluations of perinatal care, asthma management, lead screening, adolescent health care, and childhood immunizations in Ohio; perinatal care, asthma management, and preventive services for members in Colorado; and EPSDT services for school-aged children in Michigan. Mr. Miller has also been involved in conducting encounter data validation activities for physical health programs in Colorado, Georgia, Hawaii, Ohio, and Tennessee. Additionally, Mr. Miller has worked on a variety of other projects including case management reviews in Arizona and Ohio; HEDIS reporting in Arkansas, Colorado, Florida, Georgia, Ohio, and Michigan; evaluation of provider networks and benefit delivery in Arkansas, Tennessee, and Nevada; Medicaid provider surveys in Colorado; and coordination of compliance audit sampling activities. He has designed, conducted, and presented study results for persons with disabilities in Colorado, and children receiving Rehabilitative Services for Persons with Mental Illness (RSPMI) services in Arkansas. Mr. Miller oversees HSAG's contract for Arkansas Medicaid data mining and program evaluation and provides advanced statistical and analytic support for HSAG's measures management program contract with CMS.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Executive Director, Research and Analysis Team: As Executive Director of HSAG's Research and Analysis Team, Mr. Miller is responsible for oversight of all HSAG State & Corporate Services analysis activities and staff, including coordinating all HSAG analytic activities; implementing quality control processes; and providing training, mentoring, and oversight of analysis; and presenting findings and analytic interpretations in reports, graphs and charts. He acts as a SAS and GeoAccess expert resource for the Research and Analysis Team. Mr. Miller also oversees the Database Development and Analysis team, responsible for managing analytic datasets and developing electronic tools.

Director, State & Corporate Analysis: As Director, State & Corporate Analysis, Mr. Miller was responsible for coordinating HSAG analytic activities, including study design, analysis, and interpretations. He was also responsible for oversight and training of State & Corportate analyst and quality control process implementation.

Senior Healthcare Analyst, Surveys, Research & Analysis: He was responsible for the scientific soundness of study design, analysis, and interpretations of a variety of health care studies, including analysis of CAHPS®, Health Care Surveys, HEDIS®, EPSDT, network adequacy, encounter data validation and a variety of quality of care studies.

AdvancePCS, Senior Research Analyst: As a member of the Customer & Quality Research Division, he designed, implemented, and managed sampling protocols for internal and external customer satisfaction projects. Managed multiple ongoing customer satisfaction surveys, from sampling to reporting, for internal/external clients. Coordinated sampling, data management, and analysis of annual corporate-wide Client Satisfaction Survey. Assisted in the development of questionnaire design, content, and survey format (i.e., mail, telephone, Internet). Implemented innovative reporting strategies to enhance results generation and presentation. Provided ongoing training/coaching to department personnel on software applications and statistical analysis

While with IMR Scottsdale, he conducted cross-sectional/longitudinal retrospective database analyses using pharmaceutical/medical claims data. Provided analytical, methodological and statistical consulting and support for internal/external research projects. Managed daily operational procedures and timelines for internal/external studies. Assisted in designing studies and research protocols to address client needs and answer research questions. Conducted background research to support study development and interpretation of findings. Managed, coordinated and maintained client contact throughout the research process. Authored and disseminated study

findings through multiple formats including technical reports, poster presentations, publications, and presentations. Developed and maintained internal documentation for standard procedures and research activities.

Southwest Catholic Health Network, Department of Research and Evaluation, **Research Analyst**: Conducted comprehensive evaluations of current programs and company operations using industry-standard quality performance measures. Provided analytical, statistical and methodological consultation for projects in all departments. Analyzed company/member utilization and cost trends. Constructed and administered external and internal satisfaction surveys. Designed, developed and managed a survey of members' health status to identify/coordinate care. Devised internal systems for documenting project management, database development and research activities. Provided on-going training for department analysts in statistics, research design and software applications. Trained and mentored research technicians in the areas of data management and statistical analysis.

Previous Experience

HSAG, Phoenix, Arizona: Executive Director, State & Corporate Research and Analysis Team (11/07–Present); Director, State & Corporate Analysis (3/05–11/07); Senior Healthcare Analyst (12/03–3/05); 12/03-Present

AdvancePCS, Scottsdale, Arizona: Senior Research Analyst; 2/01–12/03

Southwest Catholic Health Network, Phoenix, Arizona: Research Analyst, Department of Research and Evaluation; 2/99–2/01

University of Texas at Austin, Liberal Arts Computer Lab, Austin, Texas: Instructional Lab Assistant; 8/98–12/98

IMPACT Program, Hamilton County Alcohol and Drug Addiction Services, Cincinnati, Ohio: Consultant; 6/97–12/98

Kunz Center for the Study of Work and Family, University of Cincinnati, Cincinnati, Ohio: Research Assistant; 9/97–6/98

Cincinnati Center for Developmental Disorders (CCDD), Cincinnati Children's Hospital, Cincinnati, Ohio: Consultant; 9/97–11/97

University of Cincinnati, **Department of Sociology,** Cincinnati, Ohio: Teaching Assistant; 6/97–8/97

ANAWIM Housing, Inc., Covington, Kentucky: Consultant; 10/96–12/96

Education

Master of Arts – Sociology, University of Cincinnati, Cincinnati, Ohio, 5/99

Bachelor of Science – Sociology and Psychology, Northern Arizona University, Flagstaff, Arizona, 5/96

Technical Expertise

Research/Statistic Applications: SAS, SPSS, BI-Query, MicroStrategy,

BrioQuery, Visio, Lisrel

Operating Systems: UNIX, Windows 95/98/NT/XP, MAC/OS

Certifications, Professional Organizations, and Publications

AcademyHealth member.

The Board of Trustees of the

University of Cincinnati

on the recommendation of the Faculty of the

Division of Graduate Studies and Research

of the University, does hereby confer upon

Thomas David Miller

the degree of

Master of Arts

with all the rights and privileges appertaining thereto. Given at Cincinnati, Ohio this eleventh day of June, nineteen hundred and ninety-nine.

Chairman of the Board of Trustees

Secretary of the Board of Trustees

President of the University

Vice President for Research and University Dean for Advanced Studies

Judy Yip, PhD
Associate Director, Research and Analysis Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6873
jyip@hsag.com

Qualification Highlights

Dr. Judy Yip has over 10 years of experience conducting health care research for Medicare and Medicare populations. She received her PhD from the University of Southern California in Gerontology and performed her post-doctorate work on California Medicaid home support services and senior services programs. Prior to joining Health Services Advisory Groups, Inc. (HSAG), she worked at CARF International as Senior Research Associate developing and managing survey, accreditation, and balanced score card projects for nursing homes and at SCAN Health Plan managing and providing analytic support for projects on diabetes, cholesterol treatment, depression, and geriatric telephone case management.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Associate Director: Dr. Yip is an Associate Director of the Research and Analysis Team (RAT). She manages multiple focused study, encounter data validation, data mining and program evaluation projects for the company's external quality review organization (EQRO) clients.

Senior Healthcare Analyst: As a senior healthcare analyst and SAS programmer Dr. Yip conducted focused studies, encounter data validation studies, data mining projects, and program evaluations for multiple state clients, including Ohio, Colorado, Hawaii, Michigan, and Arkansas. Additionally, she also assisted in conducting various statistical analyses using HEDIS data files. Dr. Yip is an experienced SAS programmer.

CARF International, Senior Research Associate: Major responsibilities included developing and validating consumer and staff survey instruments, collecting data and developing reports for client organizations. She conducted research on the role of accreditation in nursing home outcomes, designed research on accreditation standards and accreditation outcomes, and generated internal performance indicator reports.

SCAN Health Plan, Manager, Research and Analysis: She was responsible for defining and developing analytical/statistical plans to support the delivery of projects to internal clients, with primary responsibility for performing statistical analysis, data processing, and project deliverables. Also responsible for performing research, evaluation, investigation and designing studies to support organizational

initiatives. She participated in the conceptualization and evaluation of numerous projects including medical home visit intervention, geriatric telephonic case management, diabetic health management, anti-depressant medication compliance research, and congestive heart failure provider incentive program.

As a **Senior Healthcare Researcher** at SCAN Health Plan, she developed research designs, performed statistical analysis, and prepared substantive and technical reports as well as research publications. She participated in numerous research projects including data exploration on beta-blocker compliance, longitudinal nursing home admission study, and the CMS research proposal on examining relationships between preventive service use, utilization, and cost in Medicare Fee-for-Service beneficiary populations.

Previous Experience

HSAG, Phoenix, Arizona: Associate Director, RAT (7/11–present); Senior Healthcare Analyst (7/08–6/11); Healthcare Analyst III (3/07–7/08)

CARF International, Tucson, Arizona: Senior Research Associate; 1/06–2/07

SCAN Health Plan, Long Beach, California: Manager, Research and Analysis (11/04–12/05); Senior Healthcare Researcher (3/04–10/04); 3/04–12/05

California Center for Long-Term Care Integration, Los Angeles: Post-doctoral Research Fellow; 7/00–3/04

University of Southern California, Leonard Davis School of Gerontology, Los Angeles, California: Instructor (2000–2002); Teaching Assistant (1998–1999); 1998–2002

Arizona State University, Department of Geography, Tempe, Arizona: Teaching Assistant; 1993–1995

Kent State University, Department of Geography, Kent, Ohio: Teaching Assistant; 1991–1993

Education

PhD, Gerontology and Public Policy, University of Southern California, Los Angeles, California, 2000

MA, Department of Geography, Kent State University, Kent, Ohio, 1993

BA, Department of Geography, University of Hong Kong, Hong Kong, 1990

Technical Experience

SAS, SPSS, Microsoft Office, Krackplot (a network plotting tool), UCINET (network analysis software)

Certifications

Certified Knowledge Manager, Knowledge Management Professional Association, June 2005

Published Articles/Reports

Yip, J.Y., Nishita, C., Crimmins, E., and Wilber, K.H. 2007. High cost users among dual eligibles in three care settings. *Journal of Health Care for the Poor and Underserved*, 18(4): 950–65.

Levine, S., Yip-Reyes, J.Y., Schwartz, R., Schmidt, D., Schwab, T., & Leung, K.M. 2006. Disease Management of the Frail Elders. Disease Management and Health Outcomes, 14(4): 235–243.

Alkema, G.E., Yip-Reyes, J.Y., Wilber, K.H. 2006. Characteristics Associated with Home- and Community-Based Service Utilization for Medicare Managed Care Consumer. Gerontologist, 46(2): 173–182.

Enguidanos, S., Yip, J., Wilber, K. 2005. Ethnic Variation in Site of Death Among California Medicaid/Medicare Dually Eligible Older Adults. Journal of American Geriatrics Society, 53(8): 1411–6.

Levine, S., Unützer, J., Yip, J.Y. et al. 2005. Physician Satisfaction with a Collaborative Disease Management Program for Late-Life Depression in Primary Care. General Hospital Psychiatry, 27(6):383–91.

Shannon, G.R., Yip, Judy Y., Wilber, K.H. 2004. Does payment structure influence change in physical functioning after rehabilitation therapy? Home Health Care Services Quarterly, 23(1), 63–78.

Yip, Judy, Y., Robert C. Myrtle, Kathleen H. Wilber and David N. Grazman. The Networks and Resource Exchanges in Community-based Systems of Care. 2002. *Journal of Health and Human Services Administration*, 25(1), 219–259.

Yip, Judy Y., Kathleen H. Wilber, Robert C. Myrtle, and David N. Grazman. 2001. Comparison of Older Adult Subject and Proxy Responses on the SF-36 Health Related Quality of Life Instrument. *Aging and Mental Health*, 5(2), 136–142.

Kathleen H. Wilber, Judy Y. Yip, and staff. 2000. The Quality of Post-Acute Health Care in Los Angeles: Does Managed Care Make a Difference? Final Report to the John Randolph Haynes and Dora Haynes Foundation. Andrus Gerontology Center, University of Southern California, Los Angeles, California.

Leach, Linda S., Judy Y. Yip, Robert C. Myrtle, and Kathleen H. Wilber. 2001. An Analysis of Outcomes among Orthopedic Patients in Skilled Nursing Facilities: Does Managed Care Make a Difference? *Journal of Nursing Administration*, 31(11), 527–533.

Yip, Judy Y., Kathleen H. Wilber, and Robert C. Myrtle. The impact of the 1997 Balanced Budget Amendment's Prospective Payment System on

Patient Case Mix and Rehabilitation Utilization in Skilled Nursing. *The Gerontologist*, 42(5), 653–660.

Professional Presentations

Bonnet, P. & Yip, Judy Y. Prescription patterns of potentially inappropriate medications among older Medicare managed care beneficiaries. To be presented at the ISPOR 11th Annual International Meeting, May 20–24, 2006. Philadelphia, PA.

Yip, Judy Y., Jungki Kim, Alexander Bucur, and Eileen Crimmins. Using Linked Data to Inform the Integration Process: High Cost User Analysis. Presentation at the Annual Conference of the Gerontological Society of America. Chicago, Illinois, Nov 16, 2001.

Yip, Judy Y. High Cost User Analysis. Presentation for the California Long Term Care Integration Work Group. Sacramento, California, March 29, 2001.

Yip, Judy Y. Predictors of Hospice Provision: Comparing Home Health Agencies, Long-Term Care Facilities, and Hospitals in California. Paper presented at the Annual Conference of American Association of Geographers, New York City, New York, March 1, 2001.

Yip, Judy Y., Kathleen H. Wilber, and Robert C. Myrtle. The Quality of Rehabilitative Care in Skilled Nursing Facilities: Does Managed Care Make a Difference? Paper presentation at the Annual Conference of the Gerontological Society of America, Washington DC, November 21, 2000.

Christopher Kelly, Kathleen Wilber, and Judy Y. Yip. The Effects of the Medicare Prospective Payment System on Post-Acute Care in Skilled Nursing Facilities. 53rd Annual Scientific Meeting of the Gerontological Society of America, Washington DC, November 18, 2000

Yip, Judy Y. and Kathleen H. Wilber. Effectiveness of Integrative Mechanisms on the Resource Exchange Patterns of Community-Based Systems of Care. Poster presentation at the Annual Conference of the Gerontological Society of America, San Francisco. November 22, 1999.

Chan, Vivian W., Yip, Judy Y., and Wilber, Kathleen H. The Rehabilitation Outcome Study: Comparing Baseline Characteristics of Medicare Patients in Fee for Service and Managed Care. Paper presentation at the Annual Conference of the Gerontological Society of America, San Francisco. November 23, 1999.

Yip, Judy Y., David N. Grazman, Robert C. Myrtle, and Kathleen H. Wilber. “Community Service Delivery: A Network Perspective”, Paper presentation at the Annual Conference of Gerontological Society of America, Philadelphia. November 21, 1998.

Grazman, David N., Yip, Judy, Y., Robert C. Myrtle, and Kathleen H.

Wilber. The Networks and Resource Exchanges in Community-based Systems of Care. Submitted for presentation at the Western Management Association, 1999.

Yip, Judy Y. "Structure of Community-Based Service Delivery", Brown Bag Presentation, School of Gerontology, University of Southern California. March 30, 1998.

Myrtle, Robert C., Kathleen H. Wilber, and Judy Y. Yip. "The Quality of Post Acute Health Care in Los Angeles: Does Managed Care Make a Difference?" Faculty Brown Bag Presentation. 1997.

Pynoos, Jon, Beth Maldvin, and Judy Y. Yip. "Innovative Strategies for Supportive Housing", Gerontological Society of America, Poster Presentation, Anaheim, California, 1995.

Awards

Andrus Gerontology Center Associates Outstanding Students Award, Leonard Davis School of Gerontology, University of Southern California, Los Angeles, California, 2001.

Distinction, qualifying examination (policy), Leonard Davis School of Gerontology, University of Southern California, Los Angeles, California, 1998.

Kenneth T. and Eileen L. Norris Foundation Scholarship, 1998.

Policy Leadership in Aging Program (AARP Andrus Foundation), 1996.

Hui Oi Chow Award (represents Class Valedictorian for BA), University of Hong Kong, Hong Kong, 1990.

UNIVERSITY OF SOUTHERN CALIFORNIA
OFFICIAL ACADEMIC RECORD VERIFICATION

OFFICE OF THE REGISTRAR
LOS ANGELES, CA 90089-0912
(213) 740-7445

Date : 02-14-2012 School Code No.: 00132800

ACADEMIC RECORD VERIFICATION

Verification Released To:
JUDY YIP, PH.D.
HEALTH SERVICES ADVISORY GROUP, INC.
3133 E CAMELBACK ROAD
SUITE 300
PHOENIX, AZ 85016

CONTROL #: [redacted]

RAISED SEAL NOT REQUIRED

This transcript is not valid without the university seal and the signature of the Dean of Academic Records and Registrar. A raised seal is not required.

Douglas Shook
Dean of Academic Records and Registrar

Yip, Judy, Yun

[redacted]

Enrollment History

TERM	UNITS	DATES	STATUS	STATUS CHANGED
Spring '2000	2.0	01-10-2000 to 04-28-2000	full-time	01-11-2000
Fall '99	2.0	08-30-1999 to 12-10-1999	full-time	08-26-1999
Spring '99	2.0	01-13-1999 to 05-03-1999	full-time	01-11-1999
Fall '98	2.0	09-02-1998 to 12-11-1998	full-time	09-02-1998
Spring '98	0.0	01-07-1998 to 04-27-1998	full-time	01-07-1998
Fall '97	12.0	08-27-1997 to 12-05-1997	full-time	07-11-1997
Spring '97	8.0	01-08-1997 to 04-28-1997	full-time	01-08-1997
Fall '96	12.0	08-28-1996 to 12-06-1996	full-time	08-28-1996
Summer '96	4.0	05-15-1996 to 08-20-1996	half-time	05-13-1996
Spring '96	16.0	01-10-1996 to 04-29-1996	full-time	01-08-1996
Fall '95	12.0	08-30-1995 to 12-08-1995	full-time	08-15-1995

Degrees Earned

05/12/00 Doctor of Philosophy Gerontology

OFFICE OF THE REGISTRAR
LOS ANGELES, CA 90089-0912
(213) 740-7445

Yip, Judy, Yun
Date : 02-14-2012

This verification is valid only when it bears the seal of the University of Southern California and the signature of the Registrar. The information provided here is valid as of the date that appears on this form.

In the interest of promptness, this verification has been provided in lieu of processing the submitted form and/or providing specific requested information. Our apologies for any inconvenience that this procedure may cause your office.

---------- End Of Verification ----------

Eliza Buyong, MS
Healthcare Analyst III

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6862
ebuyong@hsag.com

Qualification Highlights

Ms. Buyong is an experienced healthcare analyst and educator. She has advanced skills in data analysis and reports generation using SAS. Ms. Buyong has served as an educator at the college level for several years in the disciplines of mathematics and statistics. She is fluent in algebra, calculus and other forms of advanced mathematics, and has structured course curricula for engineers, business students, and students of the health sciences.

In a previous position, Ms. Buyong worked as a health care analyst for the Pennsylvania Health Care Cost Containment Council to develop and implement statistical methodology and models for various council studies.

Ms. Buyong holds a Master of Science degree in Applied Statistics from Bowling Green State University, Bowling Green, Ohio, and has a BS from Northern Illinois University in Mathematics.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc, (HSAG), Healthcare Analyst III: Conducts accurate and verified descriptive and statistical analysis of patterns of care and outcomes, validates results from other analysts and prepares reports for dissemination and presentations. Conducts literature searches/reviews, assists in designing statistical analysis plans and defines case selection criteria and variable parameters.

Pennsylvania Health Care Cost Containment Council, Statistical Analyst: Developed and implemented statistical methodology for complex research and evaluation studies. Reviewed risk-adjustment methodology for outcomes reporting, performed statistical analysis, made recommendations pertaining to study design and clinical issues, and assisted in interpreting key findings for council's flagship public and commissioned reports. Performed statistical analysis on administrative hospital discharge data to review data quality including identification of problems, and made recommendations for resolution. Analyzed and prepared reports on quantified data and statistical results using SAS and/or Access.

Millersville University, Adjunct Faculty: Taught college algebra, elements of statistics, and fundamental of mathematics.

Northern Illinois University, Mathematics Instructor: Taught calculus course for science and engineering students, calculus course for business students, and pre-calculus course. Also taught a course specially designed for at risk students who do not meet traditional admission.

Previous Experience

HSAG, Phoenix, Arizona: Healthcare Analyst III; 7/04–Present

Pennsylvania Health Care Cost Containment Council, Harrisburg, Pennsylvania: Statistical Analyst; 1998–2004

Millersville University, Millersville, Pennsylvania: Adjunct Faculty; 1993–1998

Northern Illinois University, DeKalb, Illinois, Mathematics Instructor; 1990–1993

Northern Illinois University, DeKalb, Illinois, Teaching Assistant; 1986-1990

Bowling Green State University, Bowling Green, Ohio: 1985

Education

Master of Science, Applied Statistics, Bowling Green State University, Bowling Green, Ohio, 1985

Bachelor of Science, Mathematics, Northern Illinois University, DeKalb, Illinois, 1983

BGSU
BOWLING GREEN STATE UNIVERSITY
Office of Registration & Records

110 Administration Building
Bowling Green, Ohio 43403-0130
(419) 372-8441
Fax: (419) 372-7977

February 14, 2012

To Whom It May Concern:

This letter certifies that Eliza Buyong received the degree of Master of Science with a major in Applied Statistics from Bowling Green State University, Bowling Green, Ohio, on December 21, 1985.

This letter was prepared at the request of Eliza Buyong and was delivered via email to ebuyong@hsag.com. Altered or added information is not valid.

Sincerely,

Sallee J. Dildine

Sallee J. Dildine
Student Services Counselor
Office of Registration & Records

OFFICIAL SEAL
BOWLING GREEN STATE UNIVERSITY

Liwen (Laura) Jia, MS
Healthcare Analyst II

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6864
ljia@hsag.com

Qualification Highlights

Ms. Jia is a statistician and research analyst, proficient in SAS and other statistical programs. She also has experiencing teaching at the undergraduate level (Elements of Statistics). She holds a Master of Science in Mathematics with concentration in Applied Statistics, from the University of North Carolina at Charlotte, as well as a Master of Science in Chemistry from the University of Chicago.

At HSAG, Ms. Jia is responsible for data management, statistical analysis and design, and programming. Recent projects have included sample selection and analysis of weighted means for the Florida Adolescent Well-care focused study, strategic design and testing of online data collection applications for the Ohio Abortion, Sterilization, and Hysterectomy Consent Form audit project, data management and processing in support of the Colorado Child Health Plan Plus HEDIS Calculation project, and the evaluation of provider network adequacy in Nevada.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Healthcare Analyst II, Research Analysis Team: Conducts accurate and verified descriptive and statistical analysis of patterns of care and outcomes, validates results from other analysts and prepares reports for dissemination and presentations. Conducts literature searches/reviews, assists in designing statistical analysis plans and defines case selection criteria and variable parameters.

Intel Corporation, Statistical Process Control Engineer: Used design of experiment and statistical data analysis to deliver a process to meet the Process Control System (PCS), quality and yield goals for CPU product in Underfill module of assembly. Managed successful certification and transfer of process for ramp to virtual factory. As the area PCS representative, assisted with PCS development and implementation.

Department of Mathematics and Statistics, University of North Carolina at Charlotte, Graduate Teaching/Research Assistant: Developed a simulation process to compare different semi-parametric time-varying coefficients regression models for longitudinal data. The results showed the advantages and disadvantages of each model in examining the effect of treatment on the disease process over time in clinical trials. This project was funded by National Science Foundation.

Used a vector-autoregression (VAR) model to examine the dynamic interaction between oil prices, stock returns and economic activity. Developed a model to estimate the proportion of rainfall coming into the sewer system in each rain event based on the observed wet flow rate and rainfall. Derived a new hypothesis test to analyze the reliability of a psychology test. Taught undergraduate course "Elements of Statistics" for four semesters. The average scores for her session in the common final exam are always higher than the average scores of all sessions of the same course.

Previous Experience

HSAG, Phoenix, Arizona: Healthcare Analyst II; 10/06–Present

Intel Corporation, Chandler, Arizona: Statistical Process Control Engineer; 11/05–8/06

University of North Carolina at Charlotte, Charlotte, North Carolina: Graduate Teaching Assistant/Graduate Research Assistant, Department of Mathematics and Statistics; 8/01–5/05

Education

MS in Mathematics (concentrated on Applied Statistics), University of North Carolina at Charlotte, North Carolina, 2005

MS in Chemistry, University of Chicago, Chicago, Illinois, 2000

BS in Chemical Physics, University of Science & Technology of China, 1999

Technical Expertise

Proficient in SAS, JMP, MATLAB, Splus, BusinessObjects, FORTRAN and Excel.

The University of North Carolina at Charlotte

By virtue of the authority vested in them and upon the recommendation
of the Faculty, the Board of Trustees of the University
has conferred on

Liwen Jia

the degree of

Master of Science

Mathematics

In testimony whereof, the Seal of the University
and the signatures of its officers are hereunto affixed this
fourteenth day of May, two thousand and five.

Chancellor

THE UNIVERSITY OF NORTH CAROLINA AT CHARLOTTE 1946

Howard C Bissell

Chairman, Board of Trustees

Laurie Montgomery, BSCH
Project Coordinator, Research and Analysis Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6878
lmontgomery@hsag.com

Qualification Highlights

Laurie Montgomery has extensive experience with eligibility, enrollment, billing, supervision and policy writing with governmental Medicaid entities, including the State of Arizona and the State of New Mexico.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Project Coordinator, Research and Analysis Team (RAT): Provide day-to-day project assistance to the Executive Director of RAT; develop time and task schedules; identify and implement project improvement strategies; coordinate project management tasks; communicating with project partners; and complete progress reports for assigned projects.

Arizona Health Care Cost Containment System (AHCCCS) Administration, State of Arizona, Case Management Review Specialist: Completed case management program compliance audits; monitored and resolved member-specific issues, reviewed cases for special programs; recommended policy and procedural changes; and provided technical assistance to program and tribal contractors.

AHCCCS Administration, State of Arizona, Administrative Manager of Eligibility and Enrollment; Healthcare Group and Premium Sharing Programs: Managed eligibility and enrollment workflow of applicants to both programs; ensured completion of daily tasks; handled personnel issues; wrote policies and procedures; developed forms; and supervised and trained staff.

Clovis Fire Department, City of Clovis, New Mexico, Executive Administrator: Supervised office administration; processed personnel actions, coordinated recruiting and hiring process; supervised medical billing personnel; investigated medical billing issues and pursuit of payment for ambulance runs; prepared reports and updated departmental procedures; participated in various special projects including process improvement strategies.

Previous Experience

HSAG, Project Coordinator, Research and Analysis Team, Phoenix, Arizona; 12/10–Present

AHCCCS Administration, State of Arizona, Case Management Review Specialist; 3/08–11/10

Clovis Fire Department, City of Clovis, New Mexico, Executive Administrator; 8/05–2/08

Clovis Concrete Company, Clovis, New Mexico, Office Manager; 12/03–7/05

AHCCCS Administration, State of Arizona, Assistant to the Legislative Liaison, Director's Office; 3/03–10/03

AHCCCS Administration, State of Arizona, Administrative Manager of Eligibility and Enrollment, Healthcare Group and Premium Sharing Programs; 11/99–3/03

AHCCCS Administration, State of Arizona, Executive Assistant to the Deputy Director; 7/97–11/99

Other positions held during my career include **Program and Projects Specialist** with the AHCCCS Administration, State of Arizona. **Eligibility Unit Supervisor**, Bureau of Financial Eligibility, AHCCCS Administration, **Public Assistance Eligibility Interviewer**, AHCCCS Administration, and **Eligibility Worker Supervisor** and **Eligibility Worker**, Department of Human Services, State of New Mexico

Education

Bachelor of Science in Community Health. New Mexico State University, Las Cruces, New Mexico, 1982

Technical Experience

Staff management including training, coaching and supervision of subordinates; project management; writing and implementation of policies and procedures; interpersonal skills; familiarity with various State Medicaid programs and managed care concepts; ability to research, interpret and apply Federal and State laws and Administrative Rules; proficient computer skills in most Windows-based programs including Word, File Manager, Excel, PowerPoint, and Flowcharting; office management, billing and collections experience.

Certifications, Professional Organizations, and Publications

- Outstanding Alumna, College of Human and Community Services, New Mexico State University, 1987/1988
- Crimson Scholar, Program for Academic Achievement, Fall 1979 to Spring 1982
- National Dean's List, 1982
- Phi Kappa Phi Honor Society, 1982 to Present

Cheryn Wall, EdD
Director, Reports Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6740
cwall@hsag.com

Qualification Highlights

Dr. Wall has more than 25 years experience writing, editing, and producing data-driven reports for local, state, and federal agencies. She has been an editor/writer for various reports, required filings, RFP and grant applications, company and community newsletters, annual reports, research findings, speeches, news releases, press packets, and other deliverables. Dr. Wall has authored/co-authored published articles, columns, and information pieces. She has also served as a consultant in communication strategies and educational training programs. She currently teaches oral and written communication skills courses at the university level as an assistant professor (part-time).

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc., (HSAG), Director – Reports Team: As Director of the Reports Team, Dr. Wall works with the EQRO Executive Directors to develop work plans for all report deliverables and supervises the Reports Team members to translate these work plans into daily, manageable workloads. Dr. Wall has worked on report deliverables for the states of Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, Tennessee, and Vermont. She has also experience with RFPs and has worked on deliverables for TRICARE, CMS, and federal special study projects.

As a **Professional Writer**, Dr. Wall was responsible for: developing, writing, editing, and reviewing company reports, client deliverables, proposal responses, grant requests, letters of intent, and other reports/documents.

Scottsdale Unified School District, Assistant Superintendent: Responsible for: developing, writing, editing, and producing district/school documents and data-driven reports; deliverables to local, state, and federal agencies; data collection and analysis; strategic planning; media relations (including press releases, news conferences, serving as district spokesperson); district marketing plan; educational television programs and courses.

Northern Arizona University, **Assistant Professor** (part-time): Teaches oral and written communication skills courses such as Advanced Presentation Techniques; Business and Professional Speaking; Persuasion; Communication in Contemporary Affairs; and Capstone Senior Research Projects. The teaching environment includes proficiency in interactive television/distance learning as well as direct classroom instruction.

Previous Experience

Health Services Advisory Group, Inc., Phoenix, Arizona: Project Director, Reports Team (11/06–Present), Project Manager, Reports Team (3/05–10/06), Professional Writer (12/02–2/05)**;** 12/02-Present

Northern Arizona University, Phoenix, Arizona: Assistant Professor (part-time); 1999–present

Educational Consulting: 1983–2002

Scottsdale Unified School District, Scottsdale, Arizona: Assistant Superintendent, Research and Community Development, Communications Director, Director of Community Services; 1984–1999

John Carroll University, University Heights, Ohio: Instructor, Department of Communications; 1980–1982

Cuyahoga Community College, Cleveland, Ohio: Instructor, Department of Communications (part-time); 1971–1982

Loyola University, Chicago, Illinois: Instructor, Department of Communications; 1970–1971

Education

EdD – Educational Administration and Supervision, Arizona State University, Tempe, Arizona, 1998

MA – Communications, University of Michigan, Ann Arbor, Michigan, 1970

BA – Communications, Butler University, Indianapolis, Indiana, 1969

Technical Expertise

Proficient with Macintosh and PC systems. Software: Windows XP, Word, PowerPoint, Publisher, Excel, PageMaker.

Certifications, Professional Organizations, and Publications

Certifications

Certification Program in Strategic Planning

Trained Facilitator, Federal Mediation and Conciliation Services (US Department of Labor)

Professional Organizations

Valley Leadership

Who's Who in American Education

National Communication Association

American Association of School Administrators
Association for Supervision and Curriculum Development
Arizona School Administrators
Phi Delta Kappa
Phi Kappa Phi

Arizona State University

Greeting to all to whom these Letters shall come

The Arizona Board of Regents

by virtue of the authority vested in it by law and

on recommendation of the University Faculty does hereby confer on

Cheryn Heinen Wall

who has satisfactorily completed the Studies prescribed therefor

the Degree of

Doctor of Education

with all the Rights, Privileges and Honors thereunto appertaining

In Witness whereof the Seal of the University is hereto affixed

Awarded at the Main Campus

this eighteenth day of December, one thousand nine hundred and ninety-eight.

Jane Dee Hull
Governor of Arizona

John A. Pelton
President of the Board

ARIZONA STATE UNIVERSITY · GREAT SEAL OF THE STATE OF ARIZONA · 1911 · 1885 ·

Clay F. Luce
President of the University

Milton D. Glick
Sr. Vice President and Provost

Merilee Carter, BA
Senior Technical Writer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6742
mcarter@hsag.com

Qualification Highlights

Ms. Carter has more than eight years of experience working with the Reports Department at HSAG creating, formatting, and editing reports required by state external quality review (EQR) contracts. She primarily works on performance measure validation (PMV) reports, EQR technical reports, compliance monitoring, and focused study reports. Ms. Carter also works as the primary back-up on all performance improvement project (PIP) reports.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Senior Technical Writer: Edits, formats, and prepares technical reports for publication. Creates report templates and other tools. Works with management and analysts at HSAG for report organization. Creates, organizes, manages, and edits technical reports for state Medicaid programs, including California, Michigan, Colorado, Ohio, Hawaii, and Arizona.

As a senior technical writer, Ms. Carter also provides critical support throughout the request for proposal (RFP) process. She researches, works with subject matter experts, writes and edits, formats, and is responsible for production.

Health Services Advisory Group, Inc. (HSAG), Administrative Assistant III, State and Corporate Services: As a senior-level assistant, Ms. Carter worked under the direction of the Executive Director, EQRO Services, and was responsible for the timeliness and accuracy of project activities and the quality of all assigned functions and tasks within State & Corporate Services. Ms. Carter coordinated, prepared, and typed materials required for bids, proposals, letters, memoranda, and other materials from copy, rough draft, transcription machine, or other prescribed instructions, meeting deadlines in a timely manner.

Ms. Carter also worked with the Reports Department and was responsible for documenting, developing, and reviewing deliverables. She worked with editors, planners, and project staff to adhere to the project schedule.

Previous Experience

HSAG, Phoenix, Arizona, Senior Technical Writer (09/10–present); Technical Writer (03/06–08/10); Administrative Assistant III (06/04–02/06); Administrative Assistant II (02/03–05/04); 2/03–present

Kathleen A. Nielsen, P.C., Legal Secretary, Tempe, Arizona, 05/02–01/03

Liberty Mutual, Human Resources Assistant (part-time), Phoenix, Arizona. 07/01–06/02

Microtest, Inc., Human Resources Administrator/Office Assistant, Phoenix, Arizona, 07/99–08/01

Hermes of Paris, Inc., Executive Assistant**,** New York, New York, 11/97–05/99

SeaRay Sports Yachts, Service Coordinator**,** Seattle, Washington, 01/96–12/96

The Kingdome, Administrative Assistant, Seattle, Washington, 05/93–10/95

Education

Bachelor of Arts, Communications and French (Double Major), Seattle Pacific University, Seattle, Washington, 1995

Technical Experience

Proficient in Windows 10 and Microsoft Office 2010 (Word, Visio, PowerPoint, Excel)

Kristopher Ellis, BS
Senior Technical Writer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6743
kellis@hsag.com

Qualification Highlights

Mr. Ellis has over eight years of experience composing, editing, and managing print and Web-based articles, manuals, and documents in health care, academic, and information technology settings.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Senior Technical Writer: Assists with the organization and timely delivery of accurate reports and documents designed to assess and improve delivery and quality of health care for Medicaid and Medicare recipients. Create, organize, manage, and edit technical reports for state Medicaid programs, including Michigan, Colorado, Georgia, Hawaii, and Arizona. Write and edit miscellaneous internal and external projects.

Virgo Publishing, Production Editor/Staff Writer: Composed current, clinically relevant, health care-focused articles to maintain and advance publications' standing and share in national trade publication market. Managed monthly production cycle for Infection Control Today. Represented publications at national health care trade shows and conferences.

University of California—Mechanical Engineering Department, Editorial Assistant: Supported academic and administrative agendas of a dynamic, internationally renowned department. Composed, edited, and proofread complex technical manuscripts, course materials, and proposals.

Previous Experience

HSAG, Phoenix, Arizona: Senior Technical Writer (7/08–present); Technical Writer (10/06–6/08); 10/06–Present

Virgo Publishing, Phoenix, Arizona**:** Production Editor/Staff Writer, 2003–2006

University of California—Mechanical Engineering Department, Berkeley, California: Editorial Assistant, 2002–2003

Weldon Owen Publishing, San Francisco, California: Editorial Assistant/Photo Editor, 2001–2002

Brigade Corporation, San Francisco, California: Knowledgebase Editor/Team Lead**,** 1999–2001

Education	Bachelor of Science, History, Ball State University, Muncie, Indiana, 5/98
Technical Experience	Proficient in Windows 2000 and XP; Microsoft Office (Word, Visio, PowerPoint, Excel)

Alicja Wierzchowska, MA
Senior Technical Writer

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6744
awierzchowska@hsag.com

Qualification Highlights

Ms. Wierzchowska has 11 years of experience developing, writing, and editing a variety of technical manuals, marketing/advertising copy, journals, as well as researching support information. She is responsible for working with HSAG's analysts and management to translate the complexities of data analysis and research findings into direct, concise reports that meet the needs of clients.

Ms. Wierzchowska has been a member of the Reports Department at HSAG since its inception in 2002. She has worked on the California EQRO contract deliverables, including performance evaluation reports, quarterly quality improvement projects status reports, and the technical report, among others. Ms. Wierzchowska also has formatted, compiled, and proofread a wide variety of reports for the Colorado and Michigan EQRO contracts.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Senior Technical Writer: Creates report templates and other tools. Edits and prepares technical reports for publication.

The Hired Pen, Inc., Writer/Editor/Office Manager: Wrote copy for advertising, marketing, business, and creative purposes. Edited manuscripts, technical manuals, and business materials. Supervised office staff and oversaw all functions of office affairs.

The Elder Care Journal, Associate Editor/Writer: Edited, formatted, and laid out monthly journal. Wrote articles relevant to the elder care industry. Researched topics and provided ongoing assistance to staff.

Acacia Publishing, Inc., Editor: Prepared manuscripts for publication, including editing, formatting, and researching. Provided assistance to bolster product appeal and sales.

Previous Experience

Health Services Advisory Group, Phoenix, Arizona: Senior Technical Writer (4/05–Present), Technical Writer (1/02–3/05); 1/02–Present

The Hired Pen, Inc., Phoenix, Arizona: Writer/Editor/Office Manager; 5/00–1/02

The Elder Care Journal, Phoenix, Arizona: Associate Editor/Writer; 5/00–1/02

Acacia Publishing, Inc., Phoenix, Arizona: Editor; 5/00–1/02

Motorola, Phoenix, Arizona: Contractor; 9/01–1/02

Arizona State University Memorial Union, Tempe, Arizona: Building Manager; 2/98–8/99

Education

MA, English Literature, Arizona State University, Tempe, Arizona, 12/99

BA, English Literature, Arizona State University, Tempe, Arizona, 5/97

Technical Expertise

Proficient in Windows 7; Microsoft Office 2010 (Word, Visio, PowerPoint, Excel)

Arizona State University

Greeting to all to whom these Letters shall come
The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Alicja E. Wierzchowska

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Master of Arts

with all the Rights, Privileges and Honors thereunto appertaining
In Witness whereof the Seal of the University is hereto affixed
Awarded at the Main Campus
this seventeenth day of December, one thousand nine hundred and ninety-nine.

Jane Dee Hull
Governor of Arizona

Ronald J. Ulrich
President of the Board

ARIZONA STATE UNIVERSITY · 1885 ·

Clm F. Lu
President of the University

Milton D. Glick
Sr. Vice President and Provost

Colleen Angotti
Technical Writer, Reports Team

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6741
cangotti@hsag.com

Qualification Highlights

Ms. Angotti has eight years of experience creating and formatting newsletters and technical reports. As a technical writer for HSAG's Reports Team, Ms. Angotti is primarily responsible for working with HSAG's performance improvement project (PIP) team to translate the complexities of data analysis and research findings into direct, concise reports that meet the needs of clients. Ms. Angotti also works on performance measure validation (PMV) reports, external quality review (EQR) technical reports, and focused study reports.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Technical Writer: Edits and prepares PIP and quality improvement project (QIP) reports and tools for publication. Creates and documents report and tool templates. Performs online version tracking and other file management. Assists senior technical writers, as needed, and helps prepare responses to requests for proposal (RFPs).

Administrative Assistant II: Provided administrative support to the Executive Director of Nursing Homes (NHs) and Home Health Agencies (HHAs), quality improvement specialists, and fellow administrative assistants in the Centers for Medicare & Medicaid Services (CMS)-contracted federal department. Collaborated with internal and external presenters to compile handouts and create PowerPoint presentations for NH and HHA training sessions. Worked with executive directors and communications to create and disseminate the quarterly Quality Counts newsletters to NHs and HHAs statewide. Created Excel spreadsheets, graphs, and tables to track quality improvement within the federal department. Provided Microsoft Office technical assistance and support to other federal divisions when needed. Maintained several NH and HHA databases for CMS' Public Resource System (PRS) and the sub-acute team. Assisted with all travel and expense reimbursements.

Previous Experience

Health Services Advisory Group, Phoenix, Arizona: Technical Writer, State & Corporate Services, Reports Team (7/07–present); Administrative Assistant I/II, Federal Division, Sub-Acute Team (2/03–7/07); 2/03–present

Rockford Corporation, Tempe, Arizona: Home & Professional Audio Sales Assistant/Administrative Assistant for Technical Repair Department, 3/02–2/03.

SSF Imported Auto Parts, Phoenix, Arizona: Assistant Office Manager (7/99–3/02); Warranty Manager/Inventory Control Specialist (7/98–7/99); 7/98–3/02

The Italian Oven, Phoenix, Arizona: Assistant Manager (3/96–6/98); Server/Food Prep (9/93–3/96); 9/93–6/98

Education

DeVry University, Phoenix, Arizona

Technical Experience

Proficient in Microsoft Office 2010 (Outlook, Word, PowerPoint, Excel, Access, SharePoint), Adobe Acrobat 9 Professional, Oracle Database

Joy Valentine, MA
Editor

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
602.801.6745
jvalentine@hsag.com

Qualification Highlights

Ms. Valentine has more than 10 years' editing and research experience within both corporate and academic settings. She holds a Masters of Arts degree in English from East Tennessee State University.

Relevant Experience in the State and Local Government Sector

Health Services Advisory Group, Inc. (HSAG), Editor: Mrs. Valentine's work at HSAG is dedicated to helping produce well-written, timely, and accurate documents and deliverables for the company and its clients. She is responsible for reviewing and editing a variety of reports, written analyses, studies, and other documents produced by HSAG for local, state, and federal agencies. Mrs. Valentine is responsible for fact-checking, restructuring, and refining written material to produce thorough, clear, and professional reports. She works with key staff members in nearly every department—including executive directors, project managers, and auditors—to ensure that deliverables meet the highest quality standards in terms of readability, structure, grammar, punctuation, and word use.

Citigroup (Citi Holdings Division), Sr. Technical Writer/Editor/Content Manager: Documented and edited policies, procedures, and job aids for all internal operating departments, including account set-up, customer care, fraud, dispute resolution, mailroom functions, merchant funding, bank reconciliation, and risk management. Wrote, edited, and revised customer and merchant letters according to established style guides and formatting. Collaborated with legal review team, senior management, content owners and subject matter experts to ensure content accuracy and obtain signoffs. Wrote technical memorandums to communicate content revisions to a variety of audiences (from senior leadership to end users). Developed and directed a content management program for Citigroup's retail private label credit card division. Managed letter standardization project to rewrite 400+ customer letters affected by Card Act regulations. Managed project to rewrite over 1,100 policies and procedures affected by Card Act regulations and Phoenix site closure. Hired and managed contractual employees to assist with revisions.

As a Technical Writer, Mrs. Valentine documented key processes, requests for proposal; national and local industry award applications; proprietary software functionality; recognition and incentive programs;

on-line training manuals; policies and work procedures. She process mapped key processes throughout the organization to meet internal and external customer needs, and wrote and contributed to various articles for local, regional and national quality and call center magazines.

Arizona State University, Adjunct Instructor (part-time): Developed course materials for and taught a course in multimedia/technical communication.

Previous Experience

HSAG, Phoenix, Arizona: Editor, Reports Department; 8/11–present

Matrix Resources, Phoenix, Arizona: Consultant/technical editor; 4/11–7/11

Arizona State Credit Union, Phoenix, Arizona: Independent Consultant, Senior Technical Writer; 12/10

Citigroup (Citi Holdings Division), Phoenix, Arizona: Senior Technical Writer/Editor/Content Manager (1/02–11/10); Technical Writer (1/98–12/01); 1/98–11/10

Arizona State University, Tempe, AZ: Adjunct Instructor (part-time); 1/05–12/07

Northeast State Technical Community College, Blountville, TN: Adjunct Instructor; 8/97–5/99

Education

Masters of Art, English, East Tennessee State University, Johnson City, Tennessee, 1994

Bachelor of Science, English and Mathematics, East Tennessee State University, Johnson City, Tennessee, 1985

Certifications, Professional Organizations, and Publications

Other Education:

SP350 – SharePoint 2007 Advanced Core Features course graduate

Dale Carnegie Leadership course graduate

2008-9 President's Volunteer Service Award winner

Organizations:

2010-11 Climb to Conquer Cancer Planning Committee member

East Tennessee State University

Johnson City, Tennessee

The Tennessee Board of Regents for the State University and Community College System of Tennessee upon the recommendation of the Faculty has conferred on

Caressa Joy Barnett Markman

the degree of

Master of Arts

with all the rights, privileges and honors thereunto appertaining. The Tennessee Board of Regents has issued this diploma on the seventeenth day of August, nineteen hundred ninety-four.

Ned R. McWherter
Governor
Chairman, Tennessee Board of Regents

Charles Smith
Chancellor, Tennessee Board of Regents

Roy S. Nicks
President of the University

Attachment B: Mandatory Specification Checklist

2.5 Mandatory Requirements: The following mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory specifications shall result in the disqualification of the proposal. The terms "must," "will," "shall," "minimum," "maximum," or "is/are required" identify a mandatory item or factor. Decisions regarding compliance with any mandatory requirements shall be at the sole discretion of the Bureau.

HSAG has provided in this section, responses to the following mandatory requirements. HSAG understands that failure to meet any of the mandatory specifications will result in the disqualification of its proposal. Further, HSAG understands that the terms "must," "will," "shall," "minimum," "maximum," or "is/are required" identify a mandatory item or factor, and that decisions regarding compliance with any mandatory requirements shall be at the sole discretion of the Bureau.

2.5.1 Must comply with requirements listed in Attachment D.

HSAG's proposal does not include proprietary language. A signed copy of Attachment D certifying that HSAG complies with the additional contract provisions contained therein has been provided at the end of this section as well as in tab Attachment D of the technical proposal response.

2.5.2 Vendor shall provide a lead point of contact that will be immediately available by telephone and e-mail at a minimum, during business hours of Monday through Friday, 8:00 AM – 5:00 PM Eastern Standard Time (EST).

HSAG's West Virginia Project Lead, Debra Chotkevys, will be immediately available by telephone (614.221.2080) and e-mail (dchotkevys@hsag.com), at a minimum, Monday through Friday, 8:00 AM to 5:00 PM EST.

2.5.3 Vendor will provide necessary training and technical assistance to all designated DHHR and BMS staff and their contractors participating in this project during the duration of this contract.

HSAG will provide necessary training and technical assistance to all designated DHHR and BMS staff members, as well as their contractors, participating in this project for the duration of the contract.

Regarding PIPs, performance measures, and compliance activities, HSAG is uniquely qualified to provide technical assistance to DHHR and BMS staff, and the contracted MCOs. HSAG recognizes that requests for training and technical assistance may encompass more than one mandatory EQR activity, such as the need to refine performance measure technical specifications, which are also used as indicators in an MCO's PIP. Therefore, HSAG staff work collaboratively to ensure that each training or technical assistance session is appropriately staffed with HSAG experts in the respective content area. HSAG has incorporated more detailed discussions of training/technical assistance in the each of the task write-ups in Attachment A.

In addition, HSAG provides technical assistance according to EQR content areas as described below.

PIPs

Using the CMS Protocol, *Validating Performance Improvement Projects (PIPs): A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002*, as its guide, HSAG staff members are available to provide technical assistance to the MCO at all stages of PIP development and documentation. This support includes developing sound methodologies and measurable indicators, and conducting causal/barrier analyses that will assist the MCO in achieving results that demonstrate real improvement in the care and/or services provided to Medicaid members.

HSAG has been instrumental in assisting multiple MCOs in the development of collaborative PIPs. For example, in the State of Florida, several PIHPs have been conducting the collaborative PIP, *Follow-Up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*. During this collaborative process, HSAG has provided guidance during one-on-one technical assistance sessions, as well as group break-out sessions and quarterly Webinars with the participating PIHPs. During these sessions, HSAG facilitated the development of a collaborative intervention.

PMV

HSAG's performance measure validation team has provided technical assistance throughout the PMV process to numerous state Medicaid agencies and MCOs. Working collaboratively with agency staff members and the MCOs, issues are identified early on in the process and HSAG's audit staff members provide clarifications and recommendations to correct any deficiencies. Ongoing technical assistance and support is available to the MCOs throughout the year as requested/needed for any potential identified issues.

2.5.4 Vendor must comply with all Federal regulations. Vendor must meet the competence and independence requirements as specified in 42 CFR §438.354.

As the provider of EQRO services in 14 states, HSAG complies with all federal regulations and meets the competence and independence requirements specified in 42 CFR §438.354.

HSAG and its staff members have performed EQR-related work since 1990 and have demonstrated extensive skill, knowledge, and competence, as described in the section that follows.

HSAG COMPETENCE

Medicaid Recipients, Policies, Data Systems, and Processes

MEDICAID RECIPIENTS

Since 1983, HSAG has been actively engaged in evaluating the quality of care provided to Medicaid recipients, evaluating policies, and working with multiple data systems and processes. HSAG performs its EQRO functions in accordance with federal and state laws, regulations, and policies pertaining to Medicaid—including standards and procedures pertaining to the terms and conditions of the applicable waiver programs.

HSAG works collaboratively with the states for which it performs EQR services to improve the quality of care and services provided to the Medicaid beneficiaries. This effort involves working with policymakers and advocacy groups at the state level. HSAG has also worked collaboratively with state staff members to ensure that the quality improvement plans and initiatives are documented with measurable outcome criteria.

MEDICAID POLICIES AND PROCESSES

To ensure compliance with Medicaid assistance policies and processes, HSAG staff members stay fully informed of the applicable Medicaid laws, regulations, policies, and trends. HSAG staff members keep the company's EQR contract states informed of national and state issues and standards for Medicaid managed care populations, §1115 and §1915 Waivers, and changes in requirements under the BBA, HIPAA, etc. In addition to the federal arena, HSAG staff members monitor state informational sources—including related state legislation, statute, regulation, and consent decrees. HSAG staff members also stay apprised of industry standards such as NCQA, The Joint Commission (TJC), National Quality Forum (NQF), and the American Medical Association (AMA).

HSAG staff members have undertaken major policy development activities related to the health care delivery system, including technical assistance related to quality assurance/improvement program evaluation and development in Arizona, California, Colorado, Hawaii, Michigan, Ohio, Nevada, and Tennessee. HSAG acts as an advisor to the states on many Medicaid issues.

HSAG has provided a summary of its experience with medical assistance policy development activities in various states as follows:

Ohio Department of Job and Family Services

Approaches to Enrolling Members in Chronic Condition Case Management—The Ohio Department of Job and Family Services (ODJFS) requested technical assistance from HSAG to complete research on the methods to identify approaches to enrolling members in chronic condition case management.

ODJFS is developing selection criteria based on historical claims to identify members of the aged, blind, or disabled (ABD) population with seven chronic conditions: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, diabetes, coronary artery disease (CAD), hypertension, and mental health. HSAG reviewed articles, manuals, and presentations available on Web sites (as cited) to explore the following question: Do any methodologies or strategies exist to stratify members effectively based on severity levels for these disease conditions, or is it more effective to enroll into case management 100 percent of those members identified with certain conditions?

HSAG's review suggested that most of the health plans, government agencies, and consultants recommend or have used a two-part approach to cost-effective disease management (DM). First, all members with a specified IDC-9 diagnosis code, Diagnosis Related Group (DRG), or Adjusted Clinical Group (ACG), are enrolled into DM. Second, health plans use a variety of programs to stratify the severity of the disease and member compliance.

Emergency Department Diversion Performance Measure—At the request of ODJFS, HSAG's medical director completed a review for the Emergency Department (ED) diversion measure codes to be used by the ODJFS to evaluate the contracted Medicaid managed care plans (MCPs). This review included informal evaluation of the NYU ED Algorithm,[1] the Harvard Pilgrim Study (JAMA, March 2007[2]), the Commonwealth summaries of NYU studies, the ODJFS ED measure specification, and the ODJFS ED visit conditions representing 80 percent of preventable visits as well as the code spreadsheet prepared by an outside medical consultant. ODJFS used HSAG's technical assistance and recommendations to develop the performance measure to assist with policy development.

Arizona Health Care Cost Containment System (AHCCCS)

Medicaid and Medicare—HSAG worked with the AHCCCS Long Term Care System (ALTCS) to promote a change in State legislation and enhance the quality of care for ALTCS members in skilled nursing facilities by offering pneumonia vaccinations to residents. Legislation was passed to ensure that long-term care facilities provided Pneumovac to their members.

[1] The NYU Center for Health and Public Service Research. nyu ed algorithm. Available at: http://wagner.nyu.edu//chpsr/index.html?p=60. Accessed on November 30, 2011.

[2] Wharam JF et al. Emergency Department Use and Subsequent Hospitalizations Among Members of a High Deductible Health Plan, *JAMA*, 2007, *297(10)*: 1093–1102

HSAG worked with AHCCCS to establish a program with dual eligibles in nursing homes to improve care for those patients with diabetes mellitus. Dual eligibility was used to streamline billing practices for Arizona beneficiaries.

HSAG was instrumental in assisting with the implementation of a policy of analyzing chronic conditions in nursing home patients in order to help predict physical and mental health decline.

HSAG assisted with efforts to extend home health benefits to the disabled, as well as changing performance indicators for diabetes to match those of CMS. HSAG worked with AHCCCS to establish a frailty index for rate setting; CMS is using this index nationally.

HSAG worked with AHCCCS and the State to help pass legislation to offer immunizations for influenza and pneumonia to Medicaid patients in nursing homes.

Colorado Department of Health Care Policy and Financing (DHCPF)

HSAG worked collaboratively with the DHCPF to develop its quality improvement strategy and work plan. The strategy addresses a coordinated, comprehensive, and continuous effort to monitor, assess, and improve the performance of care for Medicaid recipients. The strategy includes input from stakeholders, recipients, the public, and multiple State departments.

Michigan Managed Care Quality Assessment and Improvement Division

HSAG worked collaboratively with the Michigan Department of Community Health to develop its quality improvement strategy and work plan. The strategy addresses a coordinated, comprehensive, and continuous effort to monitor, assess, and improve the performance of care to Medicaid recipients. The strategy includes input from stakeholders, recipients, the public, and multiple State departments.

HSAG performed independent assessments of the 1915(b) Comprehensive Health Care Program Waiver and the 1915(b)(c) Specialty Mental Health Developmental Disabilities and Substance Abuse Waiver. Overall, Michigan's Comprehensive Health Care Plan waiver program meets or exceeds CMS 1915(b) waiver requirements for beneficiary access to care, quality of care, and cost effectiveness of the waiver.

Nevada Division of Health Care Financing and Policy

HSAG worked collaboratively with the DHCFP to develop its quality improvement strategy and work plan. The strategy addresses a coordinated, comprehensive, and continuous effort to monitor, assess, and improve the performance of care to the Medicaid recipients. The strategy includes input from stakeholders, recipients, the public, and multiple State departments. Since 2005, HSAG has provided ongoing technical assistance to the DHCFP in the annual evaluation and revision of the State's quality improvement strategy and work plan.

HSAG provided development guidance and assessed the provision of dental services to children in the Nevada Check Up (SCHIP) program. The DHCFP began a partnership with the University of Las Vegas School of Dental Medicine (UNLV-SODM) through the contracted HMOs to improve dental care available to children in the Nevada Check Up program. HSAG continued to

provide technical assistance during an expansion process, and a UNLV-SODM corrective action plan was initiated. The DHCFP continued its commitment to an alternative delivery and payment structure for dental services by implementing a further expansion. HSAG again provided technical assistance and conducted a readiness assessment of the next iteration of dental delivery that included overseeing provider credentialing, verifying quality assurance, and assessing the scope and size of provider networks.

HSAG assisted the DHCFP in identifying and developing performance measures and standards for the Medical Assistance for the Aged, Blind and Disabled (MAABD) managed care and care coordination programs. HSAG conducted extensive research and worked with the DHCFP to select performance measures that were pertinent to the two populations. In collaboration with the DHCFP, HSAG also assisted in developing the specifications for the measures selected for the ABD programs.

The State and the HMOs formed the Racial and Ethnic Disparities Work Group to address disparities in health care utilization and outcomes. HSAG has participated in the work group and provided guidance to the DHCFP and the HMO in developing the State's Cultural Competency Plan. The work group collaborates to improve health care quality for racially and ethnically diverse populations, including those with limited English proficiency. Moving forward, the work group will identify baseline data for enrollees in both Nevada Check Up and Medicaid. In this particular endeavor, efforts are geared toward identifying racial health care disparities within the provider community, making providers aware of the disparities, and developing strategies to eliminate them.

Tennessee Department of Finance and Administration, TennCare Program

As part of the TennCare EQRO contract, HSAG keeps Tennessee informed of national and State issues, standards for Medicaid managed care populations, changes in the requirements under the BBA and other policy issues. HSAG assisted the Bureau of TennCare in monitoring health plan compliance with the requirements of the EPSDT consent decree and the Grier consent decree/dispute resolution. The Bureau of TennCare requested that HSAG assist in monitoring participating MCOs'/BHOs' compliance with the EPSDT consent decree. An on-site review of compliance was performed concurrently with the annual quality survey. Reports of findings and recommendations were provided as special reports to the Bureau of TennCare.

MEDICAID DATA SYSTEMS

HSAG's diverse technical competence is reflected in its work with a variety of Medicaid data systems and data processing procedures. As a result of multiple state EQRO contracts, HSAG analysts possess extensive experience in large data set management and analysis.

For example, in support of its contract with ODJFS for the past five years, HSAG has managed membership (including eligibility and enrollment), claims (FFS), and encounter (MCP) data from Ohio's Medicaid data system. Extracting data received on mainframe tapes from ODJFS, HSAG uses SAS to translate data from the SAS export file format to a standard text file format. These data are then processed, indexed, and stored in an active data repository from which all analytic activities are performed.

As a result of the Encounter Data Omission study (and similar projects), HSAG has also gained experience working with providers' files, such as the PCP assignment file. Additionally, previous projects related to case management, lead screening, and childhood immunizations have required the integration of external databases with Ohio's encounter data (e.g., immunization and lead screening registries, and case management systems). As a result, HSAG has not only gained working knowledge of other Ohio vendor data sources, it has also gained valuable experience in multiple data systems integration.

As the EQRO for the State of Colorado, HSAG has a direct connection to the State's data warehouse via a dedicated frame relay connection. Additionally, HSAG has implemented a virtual private network (VPN) connection using standard layered security protocols for point-to-point and/or remote access to Colorado's data warehouse. Both solutions provide HSAG with the online capability to access and process Colorado's encounter data and query subsystem, Business Objects of America (BOA). The BOA subsystem contains all member eligibility information, provider data, hospital claims, ambulatory claims, EPSDT encounter data, and pharmacy data. HSAG's responsibility has included downloading the entire BOA subsystem to calculate HEDIS measures requested by the State. The data downloading, as well as the process itself, involved considerable validation. In addition to the BOA download, HSAG has performed enrollment calculations and various queries for specific MCO-focused studies. HSAG has two staff members specifically trained to use the BOA subsystem.

HSAG's contract with the State of Tennessee's Medicaid agency, TennCare, required an evaluation of the adequacy of the complete TennCare provider network, which covers approximately 1,400,000 Medicaid managed care enrollees and the corresponding 900,000 care contributors necessary to support them. In addition, HSAG is required to evaluate the completeness and accuracy of the encounter and claims data generated by those care providers periodically. These ongoing processes require continual data management in terms of extraction, manipulation, warehousing, and analysis.

Since July 2010, HSAG has served as the Data Mining and Program Evaluation contractor with the State of Arkansas. As the key analytic support for the Division of Medical Services, HSAG's staff members are responsible for generating key analyses used in the ongoing management and evaluation of existing Medicaid programs. Using business objects, HSAG's staff members have direct access to Arkansas' Medicaid data warehouse and decision support system. Depending on the State's requirements, HSAG analysts build custom queries to extract the necessary claims data and supporting member- and provider-related information. Working extensively with State IT staff, HSAG analysts have developed a comprehensive understanding of Arkansas' information system and are able to adeptly navigate the nuances of all claim types (e.g., medical, behavioral health, laboratory, dental, inpatient, long-term care, etc.). HSAG's work with Arkansas' Medicaid data systems has included quarterly physician and hospital profiles, evaluation of key drivers of emergency department utilization, hospital readmissions, and behavioral health service and cost utilization scans. Whether using data to select samples for medical record review and HEDIS calculation or mining data for critical information in monitoring program effectiveness, HSAG has developed considerable experience working with large Medicaid data warehouses.

Managed Care Delivery Systems, Organizations, and Financing

MANAGED CARE DELIVERY SYSTEMS AND ORGANIZATIONS

In addition to working with MCOs and PIHPs to complete EQRO activities, HSAG has demonstrated experience working with the following:

Medicaid Fee-For-Service Programs: HSAG has provided EQR services to Medicaid FFS programs in a number of states. The most notable of these are the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program), since 1990; the State of Colorado Department of Health Care Policy and Financing (the Colorado Medicaid program), since 2001; the State of Nevada Division of Health Care Financing and Policy (the Nevada Medicaid program), since 1999; and the Hawaii Medicaid program since 2001. All of these state Medicaid programs have an unassigned FFS program component to their EQRO contracts. Some of the projects HSAG has undertaken for these states' FFS programs include focused studies (e.g., prenatal care, immunization status, access to preventive care for persons with disabilities, and Early and Periodic Screening, Diagnosis, and Treatment services for children), HEDIS report validation studies, consumer satisfaction surveys, and medical utilization for patients in hospitals and skilled nursing facilities.

Nursing Home Diversion Program (NHDP): The NHDP is administered by the Florida Department of Elder Affairs in consultation with the Agency for Health Care Administration (AHCA) and is designed to provide frail elders age 65 and older with an alternative to nursing home care. The program offers integrated acute and long-term care services to dually eligible Medicare and Medicaid recipients by contracting with managed care organizations and other qualified providers. As the EQRO for Florida's Agency for Health Care Administration, HSAG reviews and validates the health plan's PIPs and performance measures, and also provides recommendations regarding areas for improvement.

Primary Care Case Management: HSAG conducted readiness reviews for the Colorado DHCPF's Regional Care Coordination Organizations (RCCOs). RCCOs are hybrid entities that meet the CMS definition of primary care case managers (PCCMs) and also have the characteristics of regional accountable care organizations (ACOs). HSAG assisted the State in developing the review criteria, tools, and review process. HSAG conducted on-site reviews of the seven RCCOs to determine each RCCO's level of readiness to begin operations and provided individual RCCO reports with an assessment of each organization's level of readiness. Currently, HSAG is collaborating with the DHCPF to develop external quality reviews to assess each RCCO's progress in the first year of operation.

Ohio Care Coordination Program: In partnership with ODJFS, HSAG has worked to redesign the Medicaid care coordination program in response to a State directive to create better health, better care, and costs savings. ODJFS discovered a medical hot spot in which a very small percentage of high-cost cases account for most of Ohio Medicaid's budgeted health care spending. The data revealed that 1 percent of the Ohio Medicaid population accounts for 23 percent of the total Medicaid spending. To address this high-cost population, ODJFS is requiring its managed care plans to focus on this top 1 percent, representing the most vulnerable and high-need members. ODJFS consulted with HSAG, which has provided assistance to ODJFS as part

of the redesign to identify "manageable" versus "non-manageable" conditions that could benefit from care management services. Additionally, HSAG has developed proposed methods for care management program performance measures. These measures include a monthly high-risk care management rate as well as an emergency department utilization rate, inpatient hospitalization rate, and overall Medicaid costs of high-risk care management members. These measures will assist the State in determining the effectiveness of its quality improvement strategy. The program redesign will be implemented in July 2013.

MANAGED CARE FINANCING

Understanding the financing intricacies of Medicaid is an important component of understanding each state's EQR needs. Improving quality is often a balance between achieving quality improvement over a specified period of time and the funding that is available to support that improvement. Over the past several years, HSAG staff members have assisted states in the development of realistic quality improvement strategies that have considered the federal and state funding available during times of state budget deficits. An example is provided below:

HSAG developed a methodology for combining data collected by the State of Georgia's Department of Community Health (DCH) and its contracted care management organizations that allowed the State to report Children's Health Insurance Program Reauthorization Act (CHIPRA) rates to CMS without having to initiate additional, costly medical record abstraction. The DCH was most recently highlighted in the 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP report released by the Department of Health and Human Services for reporting the highest number of CHIPRA measure rates. The methodology HSAG created will allow the State to report additional measure rates in subsequent years.

HSAG's executive vice president, Richard Potter, oversees all of HSAG's state Medicaid external quality review contracts and has extensive experience in, and knowledge of, health care quality systems and managed care programs as they relate to performance-based contracting, and in Medicaid reimbursement systems. He has managed projects to establish risk-adjusted rates, conducted operational and financial health plan reviews, managed quality assurance programs, developed capitation rates, and conducted health plan rate negotiations. As deputy director of AHCCCS from 1990 to 1998, he designed, planned, and implemented Arizona's Children's Health Insurance Program, KidsCare, and he successfully gained consensus on a defined benefit package, eligibility criteria, and a member enrollment process for a $60 million State premium sharing program that provided health insurance to uninsured working individuals and their families.

Additionally, the knowledge HSAG staff members have about the capitated environment in which services are being provided can help ensure that EQR services are targeted toward realistic improvement. Specifically, HSAG staff members have assisted states in developing quality improvement plans that were consistent with the state's managed care financing mechanism. For example, in Tennessee, HSAG staff members helped develop an annual quality survey geared toward contract compliance that considered the low-risk administrative services organization (ASO) financing arrangement with the MCOs compared with traditional risk-based capitation.

HSAG staff members also have experience in developing MCO capitation rates in four of the states in which it conducts EQR activities. HSAG's knowledge of how these states finance their Medicaid programs contributes to its ability to provide appropriate and effective EQR activities.

Quality Assessment and Improvement Methods

QUALITY ASSESSMENT AND IMPROVEMENT METHODS

For quality assessment and improvement projects, HSAG typically follows the well-established method of setting a baseline; working with the state to develop, perform, and assess interventions; and remeasuring. HSAG staff members have demonstrated, hands-on experience with the following types of quality assurance and performance improvement projects:

Conducting Compliance Reviews

HSAG is uniquely qualified to conduct on-site reviews of MCOs to evaluate compliance with regulatory and contractual standards, perform information systems assessments, identify opportunities for improvement, and make recommendations for implementing improvements. HSAG staff members have performed on-site quality reviews of Medicaid health plans for more than 20 years. These reviews have ranged in complexity from HEDIS compliance audits, to the compliance evaluation of health plans' internal quality programs and quality of care studies, to more intense and comprehensive reviews of the EPSDT services provided to Medicaid enrollees. Where plan performance was not at the state-desired levels, HSAG was instrumental in assisting the states with implementing and reevaluating corrective action plans and achieving performance improvement.

Analyzing HEDIS Audited Data

One of the core principles of HSAG's quality assessment efforts for Medicaid managed care programs is to assure that health plans are delivering the highest quality of care based on established standards and requirements. Much of the monitoring involves compliance with established performance standards such as HEDIS, allowing a comparison of the health plans' performance to each other and against national benchmarks. HSAG has conducted more than 450 HEDIS compliance audits for MCOs nationwide since 1999.

HSAG has assisted several state Medicaid agencies and MCOs with performance improvement using HEDIS-related data. For example, in the State of Michigan, HSAG has presented HEDIS results to MCOs at yearly conferences on behalf of the Michigan Department of Community Health for the past four years. HSAG provides the MCOs with information on how to improve performance pertaining to data collection techniques, data completeness, encounter/claims processing, and QI workgroup establishment. Several key HEDIS indicators in the State of Michigan have increased substantially over the years.

Conducting Performance Improvement Projects

HSAG successfully validates more than 300 PIPs per year in a manner that is consistent with the CMS protocol, *Validating Performance Improvement Projects (PIPs): A protocol for use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 2002.

HSAG's PIP Summary Form and PIP Validation Tool are being used to validate PIPs in 10 state Medicaid managed care programs (California, Colorado, Florida, Georgia, Hawaii, Illinois, Michigan, Nevada, Ohio, and Vermont). The validation process includes structured assessment and scoring methods and also includes an interrater reliability verification process to ensure that the CMS validation protocols are consistently applied by multiple PIP reviewers.

The PIPs validated by HSAG are submitted by a variety of MCOs, including Care Coordination Networks (CCNs) and other managed care entities. HSAG has validated PIPs across an extensive list of topics, including diabetes care, well-child care, emergency department utilization, childhood obesity, coordination of care, access to care, mental health follow-up, utilization measures, seclusion and restraint reduction, prenatal care, consumer satisfaction, and timeliness of care. HSAG has reviewed HEDIS-specific indicators as well as non-HEDIS indicators for clinical and nonclinical studies. HSAG's exposure to this variety of topics and health plan models allows HSAG to provide helpful technical assistance to coordinated care entities so they may develop, structure, and conduct successful PIPs that bring about true and sustained improvement.

Conducting Focused Quality of Care Studies

The following is a list of focused studies topics that HSAG has conducted on behalf of various states in support of its EQRO contracts. The table highlights HSAG's depth of experience and versatility in addressing states' needs.

State	Focused Study Topic	Method/Medical Record Review
Arizona	Behavioral Health Quality of Care (2004/2007)	Medical Record Review
	Substance Abuse Treatment &Prevention (2008–2011)	Medical Record Review and Staff/Client Interviews (2008 only)
	AHCCCS Immunization 2003–2007	Administrative Data Study
Arkansas	Childhood Immunization Study 2009–2010	Medical Record
	Childhood Immunization Study & Adolescent Immunization 2011	Medical Record
Colorado	Asthma Management (2003/2004)	Administrative Data Study
	Perinatal Care (2003/2004)	Hybrid
	Access to Preventative Services for Disabled Persons (2004/2005)	Administrative Data Study
	EPSDT (2004/2005)	Provider Survey
	Adolescent Well Care Services (2005–2008)	Administrative Data Study
	Diabetes Care (2005/2006)	Administrative/Medical Record Review
	Asthma Management (2006/2007)	Administrative Data Study
	Perinatal Care (2006/2007)	Administrative/Medical Record Review
	Utilization of Services for Members with a Diagnosis of SMI (2007–2008)	Administrative Data Study
Florida	Adolescent Well Care Services (2006/2007)	Medical Record Review
	Special Health Care Needs (2006/2007)	Qualitative Study (20 provider groups)
	Behavioral Health Authorization (2007/2008)	Qualitative Study (28 provider groups)
Georgia	Encounter Data Validation—EPSDT (2009/2010)	Medical Record Review
Hawaii	Encounter Data Validation (2005–2008)	Administrative/Medical Record Review

State	Focused Study Topic	Method/Medical Record Review
Michigan	EPSDT (2005/2006)	Administrative/Medical Record Review
	SMI/DDD Medical Service Utilization Patterns (2011)	Administrative Data Study
Ohio	Asthma Management (2003/2004)	Medical Record Review
	Perinatal Care (2003–2005)	Medical Record Review
	Immunizations (2003/2004)	Medical Record Review
	Encounter Data Validation (2003–2011)	Medical Record Review
	Encounter Data Omission (2003–2007)	Medical Record Review
	Lead Screening (2004/2005)	Medical Record Review
	Adolescent Health Care (2004/2005)	Medical Record Review
	Smoking Cessation (2005/2006)	Medical Record Review
	Case Management (2005/2006)	Medical Record Review
	Healthchek-EPSDT (2006/2007)	Medical Record Review
	Women's Preventative Health (2006/2007)	Administrative/Medical Record Review
	Abortion, Sterilization, and Hysterectomy Study (2006, 2009–2011)	Medical Record Review

In each of the completed studies, HSAG has used information gleaned from members' medical records to develop actionable recommendations designed to improve the quality of care rendered by providers and received by Medicaid recipients. HSAG has gained the experience necessary to use medical record review to translate health care information into activities that improve health outcomes for Medicaid populations.

HSAG understands that medical record review plays a valuable role in monitoring and improving the quality of services rendered to Medicaid enrollees. As the "gold standard" for information related to patient care, medical record reviews provide a mechanism for measuring and improving the quality of care. For more than 20 years, HSAG has conducted medical record reviews to track state and health plan performance across a variety of both clinical (e.g., asthma management, EPSDT services) and nonclinical (e.g., case management) measures, to generate rates and conduct comparative analysis among health plans and evaluate improvement over time. For example, HSAG conducted a clinical record review project for the State of Arizona that assessed the behavioral health system's performance across several clinical standards, including assessments and treatment planning, coordination of care, quality clinical outcomes, medication practices, and outreach and engagement. As a result of HSAG's ongoing medical record review and technical assistance, notable improvements in performance scores were realized for several standards.

Developing and Administering Surveys

As an industry leader in measuring the effectiveness of health care, HSAG has extensive experience in survey management, instrument design, and report development. In 1995, building upon its extensive work in the Medicaid and Medicare arenas, HSAG began to develop health outcomes expertise, including patient-reported health status, quality-of-life, and satisfaction surveys. HSAG quickly became a leader in the field by designing and conducting scientifically sound quality-of-life and outcomes studies and collecting, analyzing, and reporting data for federal and state agencies, managed care plans, hospitals and academic medical centers, and private sector health care companies.

HSAG has conducted numerous health care studies for government, academic, and private organizations. HSAG's success reflects its understanding of consumer and beneficiary needs integrated with the requirements of applied research combined with excellent attention to detail. HSAG designs survey instruments that are technically sound, yet extremely user-friendly, to ensure reliable data and high response rates. This skill has been fundamental to HSAG's success in achieving high response rates in surveying patients and providers across the entire health care spectrum. Respondents have included multilingual (e.g., Spanish, Native American), cross-cultural, and hard-to-reach rural populations.

HSAG's extensive expertise in the area of surveys enables it to efficiently and effectively integrate Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other survey findings with findings derived from other quality improvement activities to achieve performance improvement.

HSAG:

- Has been an NCQA-Certified HEDIS (CAHPS) Survey Vendor since the inception of the program in 1999.
- Possesses a wealth of knowledge from having performed CAHPS and other survey-related activities for 12 state Medicaid agencies including Arizona, California, Colorado, Florida, Hawaii, Illinois, Michigan, Nevada, Ohio, Oregon, Tennessee, and Washington.
- Has administered over 500,000 surveys to Medicaid members in a wide array of programs (including both disabled and TANF members).
- Has administered over 10,000 provider surveys to specialist and non-specialist providers in a variety of practice settings.
- Conducts surveys in accordance with the CMS Protocol for Administering or Validating Surveys, and is thoroughly familiar with all eight specified activities that must be undertaken to ensure methodologically sound surveys.
- Ensures intensive quality control both internally and with its longstanding subcontractors.
- Possesses expertise in analyzing CAHPS data for state Medicaid agencies and Medicaid managed care plans, including plans serving special needs populations.
- Possesses innovative report production technology that automates the report production process.
- Has developed novel survey products that integrate survey data with data from other sources (e.g., burden of disease estimates derived from claims/encounter data, HEDIS data, and other common EQR data sources).
- Is the only QIO in the nation that was selected by CMS to contract for the Health Outcomes Survey for Medicare and to implement Hospital CAHPS (HCAHPS).

In addition to its internal expertise, HSAG also partners with some of the most renowned survey research groups in the country, including, but not limited to:

- National Committee for Quality Assurance (NCQA)
- RAND
- Expert consultants from Harvard Medical School

- DataStat, Inc.

HSAG's staff experience and approach to the development and administration of surveys offers innovative quality assessment and performance improvement methods.

Research Design and Methodology, including Statistical Analysis

HSAG's research and analysis team has extensive experience conducting a variety of analytical projects ranging from case review record sampling and statistical analyses to comprehensive clinical and nonclinical research projects. HSAG brings more than 30 years of combined experience in health care informatics, research design, analysis, and reporting, including sampling, data management, medical record procurement and abstraction, and statistical analysis. HSAG has gained experience in a variety of study designs, clinical conditions, nonclinical areas of care, process and outcome measures, population characteristics, data collection and processing methodologies, statistical analyses, and provider/payer arrangements throughout its long history of administrating quality of care studies. From simple random samples to complex multi-stage, cluster sampling, and from simple performance rates to risk-adjusted, weighted averages, HSAG's experienced analysts use their knowledge to apply appropriate analytic methods to ensure the highest quality of studies. More importantly, HSAG's analytic team is able to translate complex statistical concepts and quantitative and qualitative research into operational goals and standards and improvement activities. The key to HSAG's success has been its comprehensive grasp of research principles and ability to apply them in real-world analyses.

All HSAG studies are conducted using proper research design and appropriate statistical analysis in order to provide credible information to evaluate performance and measure improvement. HSAG offers state Medicaid agencies a core group of clinicians, health care analysts, epidemiologists, biostatisticians, and information management specialists who are involved in methodological design, validity and reliability studies, data analysis, and report preparation. Individuals employed are highly qualified, having bachelor's and master's degrees in biostatistics, applied statistics, health care economics, epidemiology, and business. In addition, several senior program and management staff members have doctoral degrees and backgrounds that include research and data analysis.

The HSAG Informatics Team has supported both state and federal clients in the research areas of methodological design, validity and reliability assessment, data collection and management, statistical sampling, comprehensive data analysis, and client-tailored report preparation. The following paragraphs detail HSAG's experience in the areas of research design and methodology.

As part of a Medicaid program research evaluation, the HSAG Informatics Team conducted a comparison of selected performance measures for pre- and post-statewide Medicaid expansion of managed care for a statewide Medicaid Managed Care Program. To identify comparable populations for the two time periods, the Informatics Team identified demographic and disease covariates for each member. These covariates were used to derive propensity scores in order to match pre- and post-study samples. The propensity scoring methodology was used to reduce biased results and control for multiple confounders simultaneously by ensuring that comparable

pre- and post-study samples were evaluated. After determining a propensity score for each member, an algorithm was used to match cases. A Chi-square test, *t* test, and effect size calculation were used to ensure that statistically significant differences did not exist between the populations (i.e., the pre- and post-study populations were comparable).

For another project, the HSAG Informatics Team developed three novel performance measures to evaluate member utilization and costs in a statewide Medicaid managed care program's high-risk care management programs. Due to regression toward the mean (RTM), the overall mean of this high-risk population's utilization and costs should improve (i.e., decrease) over time whether or not an intervention (such as care management) is implemented. To mitigate this phenomenon, the HSAG Informatics Team recently developed an RTM and risk adjustment protocol that will be used to evaluate these high-risk care management measures. The calculation of an RTM effect will be used to adjust the observed change in order to derive a change attributed to care management. In addition, the Informatics Team is developing a trend factor and the different components that comprise the overall trend factor (i.e., changes in utilization, fee schedule, and medical technology) for an evaluation of overall cost for these high-risk care management members.

For a new CMS/Center for Medicare and Medicaid Innovation (CMMI) initiative, the HSAG Informatics Team is overseeing an impact analysis that determines the effect of a national program on hospital adverse events and readmission rates. As part of this activity, difference-in-difference models will be developed to determine the impact of the national program regarding hospital behavior, total cost savings, hospital and contractor factors/interactions that led to successful outcomes, and negative unintended consequences. Furthermore, the Informatics Team is designing a hospital-based audit methodology to determine if hospitals involved in the national program had a 20 percent reduction in both readmissions and adverse events.

Sufficient Physical, Technological, and Financial Resources to Conduct EQR-related Activities

PHYSICAL RESOURCES

HSAG has the facilities, support services, and office equipment resources to conduct all required EQR and EQR-related activities.

HSAG's headquarters are in Phoenix, Arizona, where the company has conducted business since 1979. In the course of HSAG's 20-plus years of collaboration with state Medicaid clients, the company has established a very high level of responsiveness to contract requirements, as well as innovative solutions that go well beyond contractual requirements. HSAG's collaborative style has become an integral part of its corporate culture and history.

HSAG has satellite offices located in Little Rock, Arkansas; Glendale, California; Denver, Colorado; Honolulu, Hawaii; Columbus, Ohio; and Tampa, Florida.

TECHNOLOGICAL RESOURCES

State-of-the-Art Information Systems and Technological Resources

HSAG recognizes how critical information systems are in conducting EQR and other health care quality improvement activities in which data warehousing and analyzing and reporting timely information are required. HSAG is committed to ensure its information systems operate and are maintained at peak performance, yet retain flexibility to modify the system when necessary to perform EQR tasks. This effort requires an effective life cycle management program to ensure that the technology infrastructure, including both hardware and software, sustains the ever-increasing demand to provide information faster and more efficiently.

HSAG maintains a robust and secure system for managing quality review information based on sound information processing principles. Superior, life-cycle managed equipment aids in the rapid and accurate data processing and improves cost efficiencies. HSAG's data processing resources and equipment use network servers (Windows Server 2008) configured to benefit from a redundant array of independent disks (RAID 5) with a reliable, secure gigabit network backbone and storage area network (SAN). The software running on the servers, workstations, and laptops is state-of-the-art technology and was selected because it provides enhanced security, reliability, scalability, and simple maintenance for the entire network. HSAG uses Cisco network hardware components (i.e., firewalls, switches and routers) and Dell servers and workstations as the computing platforms running on a gigabit network with 100/1000 baseT connectivity to the desktop.

HSAG also uses SharePoint Services, and Office SharePoint technology to deliver the ability to securely access all corporate software applications and software tools from anywhere in the country where Internet access is available, including secure wireless Internet access. As a result of the extreme flexibility of these technologies and the technical resources employed at the corporate office, HSAG is able to establish a virtual corporate presence or offer clients a tailored Internet presence very quickly. This presence offers secure application access as well as 128-bit encrypted data/file transfer capability.

Entry into HSAG's network is through a secure Cisco firewall, which is capable of supporting many simultaneous virtual private network (VPN) connections configured with all high-risk ports closed to Internet protocol traffic, thereby assuring the security and integrity of the network resources. To facilitate rapid communication and data flow, HSAG has installed high-speed wideband connectivity to all our state offices throughout the country. In order to accommodate the increasing data warehousing demands from our clients, HSAG has several high-capacity, high-availability storage systems, including network accessible storage (NAS) and a storage area network (SAN). HSAG has the ability to expand this equipment further as storage demands require, enabling accommodation of very large data sets. HSAG is able to use all available software with the assurance that all data are protected via various methods including SAN replication, virtual server replication, disk-to-disk copy, and centralized tape backup services. Our corporate IT infrastructure also provides clustered, redundant server capacity to assure maximum availability, efficiency, and reliability.

HSAG's Ability to Maintain Large Data Files Provided by the State and Use of

Appropriate Software to Ensure File Exchange

HSAG has the capacity to access, process, maintain, and store the large data files provided by Medicaid agencies and the MCOs efficiently and accurately. HSAG has sufficient hardware and software to handle all of the data demands. In addition, HSAG has the ability and technologies to seamlessly translate virtually any database into another type or format. This capability enables HSAG to quickly create SAS files for analysis and return data to clients in the format they need.

HSAG has experience obtaining and storing large data files. For many of its EQR efforts, HSAG has created a data warehouse capable of housing the data files to facilitate analysis and reporting. These data warehouses are included in a company-wide daily data backup plan to ensure data availability as well as minimize the need to repeat data downloads from the MCOs or the State.

HSAG currently uses SharePoint 2010, SAS, DBMS/Copy, Deltek, Visio 2007, Microsoft Windows 7, Microsoft Office 2010, Microsoft SQL, and Adobe Systems applications in its daily business activities. For data file transfers, HSAG employs secure file transfer protocol (FTP and SFTP) incorporating industry standard data encryption. In addition to file transfers, these HSAG customer portals can facilitate data/file/report distribution to the individual MCOs and rolled-up aggregate reports and statistics for the state.

HSAG has implemented HIPAA-compliant technologies to ensure client confidentiality in all phases of work. HSAG's confidentiality policies apply to all personnel and subcontractors and include all levels of client data—from medical records, to electronic/administrative data, to grievance and appeals files. The table below identifies HSAG's core data center hardware resources at its Phoenix offices:

#	System	Function
1	Dell R900 Server(s)	Core Windows 2008 services and management
2	Dell 2950 Server(s)	Core services: Exchange 2007, SharePoint, SAS, Deltek, SQL, Web services, etc.
3	EMC SAN	Data storage, server virtualization clustering, backups and virtualization
4	Cisco 5540, 4510, 3750, 9200	Firewall, main gateway, core switching, workstation switching, fiber switching

Web Portal Facilitates Online Data Entry and Real-Time Reporting

HSAG has established SharePoint partner and/or File Manager portal environments for most of our clients/customers to assist collaborations on a variety of quality improvement projects, as well as provide a secure environment in which to transfer data, files, and reports. A properly configured SharePoint or File Manager site allows for secure access to a single virtual space within which all information and applications required for a report and/or project are immediately and simultaneously accessible to all participants. Individual views of the portal are created based on administratively controlled permissions and rights to applications and documents. Access to the portal Web site is available to any authorized and authenticated individual with a PC or laptop that has a connection to the Internet and supports Microsoft Internet Explorer V7 or later.

Each portal allows secure anytime, anywhere access to all contract-relevant information and applications (where appropriate) through a single-user profiled interface from virtually any computing device that has Internet connectivity and supports Microsoft's Internet Explorer V7 or higher. Some of the advantages to these technologies are that they:

- Single space for "right now" access to all contract information based on individualized permissions and access rights.
- Facilitate dissemination of reports, documents, alerts, files, contract information and interactive exchanges with project personnel.
- Provide individualized access to applications mentioned above and any other applications made available for a particular project.
- Provide an electronic virtual meeting place for all project personnel that can be used for training, online collaboration and communication.
- Eliminate the potential problem of e-mail servers configured to limit the size of files that can be attached to e-mails, which if exceeded, rejects the e-mail and the attached file.

Through HSAG's secure file transfer capabilities, files can be downloaded from the portal environments or uploaded to them. Documents can be read online, saved to local drives, or printed locally. Data can be entered into online applications created specifically for projects, sent to a database, and dynamically reported with a few mouse-clicks. All of these activities can be accomplished in a very secure environment that includes encryption, individual authentication, firewall protection, and rigid administrative policies controlling access, levels of permission, and rights by group role or by individual. Secure electronic file transfers have eliminated the time needed to send products between organizations through standard U.S. mail, courier or inherently unsecure e-mail.

HSAG's Web portals bring together, in one virtual space, all relevant e-tools, documentation, files, project plans, Internet links, FTP sites, etc., that are used to develop and distribute required reports and deliverables. Formal reports can be posted as they are completed and thus made instantly available to all who have appropriate security permission/access.

Software Applications

HSAG uses Windows 2008 with the latest service pack as the network operating system, and Windows 7 for the desktop environment. Microsoft administrative tools (SCCM and others) and SolarWinds are used for management, real-time monitoring and control of network elements. Total network, data, endpoint, Web, and Internet protection and security are provided by McAfee software suites.

In addition to McAfee Total Protection, desktop and laptop computers are loaded with common office application software. These applications include the Microsoft Office 2010 Suite providing MS Word, Excel, PowerPoint, and Access in an integrated application suite. Specialty software including SAS and other programming languages and statistical software are loaded on computers used by HSAG's analysts and programmers. Programmers use the latest version of Visual Studio.NET. In addition, HSAG's Communications and Reports departments use graphic design, advanced text formatting and editing software to produce reports and other documents

and can quickly adjust to changes to ensure customer reports are produced rapidly and accurately.

Disaster Planning

While technical problems are inevitable, in a well-maintained and secure system with adequate backup, few problems should ever reach disaster levels. HSAG has implemented an inter-site corporate backbone with several redundant physical sites and service nodes that provide automated or minimal intervention disaster recovery services and site replication. A data- and service-relevant suite of SAN, disk-to-disk, and/or tape backups are performed on the servers and data storage monthly, weekly, daily or continuously, depending on the type of information stored. Physical tape media are rotated on a 21-day cycle to ensure that no data are lost. Tape backups are transported weekly to an off-site secure vault storage. HSAG tests its corporate disaster recovery plan at least annually.

Security of Information

HSAG takes the protection of confidential information and protected health information (PHI) very seriously. As with our other EQR activities, HSAG has implemented a thorough compliance, awareness and protection program that includes recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations:

Confidentiality: All employees receive confidentiality, privacy and security training to inform them of their responsibilities when working with state and federal health oversight agencies in maintaining the confidentiality and privacy of PHI. Employees are required to sign a confidentiality/non-disclosure agreement as part of their employment as well as adhere to the policies and procedures that assure continued protection and security. To keep awareness at a high level, team members receive periodic confidentiality awareness reminders throughout the year through various means (e.g., e-mail, bulletin board postings, staff meetings, etc.).

Physical Security: All HSAG facilities and offices are alarmed, and access is restricted to authorized personnel only. In the Phoenix offices, areas containing sensitive information are accessed with badges containing embedded electronic chips that uniquely identify each individual. In addition to controlling/limiting access to all sensitive areas, the security system has electronic logging of individual access activity 24 hours a day, 7 days a week. Exceptions are monitored and escalated for action as appropriate. In other facilities, access to areas containing confidential information is protected by electronic combination locks. Protection of medical records can be tracked electronically with barcoded log-in/log-out procedures. Each medical record then receives a unique barcode used to track the record.

Electronic Security: Access to the data center, where the data warehouse is located, is controlled by an electronic badge reader and limited to information technology personnel. Network and data warehouse access is controlled by individual passwords that require renewal every 60 days. Access to confidential information stored in the information systems is controlled by granting access rights/permissions on a minimal need-to-know basis. To ensure data availability, HSAG performs continuous remote data replication and scheduled backups to local disk and/or tape systems.

Operations: Daily operations include policies for ensuring confidential information is secured at the end of the day to prevent inadvertent disclosure to unauthorized personnel. Confidential information in paper form is stored in a separate, secure room or in locked file cabinets, accessible to authorized personnel only.

Access Control Assurance: To ensure continuous control of security access to confidential or protected information, processes have been developed to ensure individual access is immediately removed or adjusted for any individual that has been terminated or whose accesses need to be adjusted. The process begins with notification from Human Resources or the individual's immediate supervisor to the director of information systems and the facilities manager that access is to be removed or adjusted. Information Systems adjusts the individual's access rights and Facilities Management adjusts physical access accordingly. In all other cases, physical and electronic security access is validated semi-annually to ensure only authorized personnel have access to confidential or protected information. Access rights are granted on an individual, need-to-know basis.

FINANCIAL RESOURCES

HSAG is a financially sound and well-managed organization. The company has been in existence since 1979 and has maintained steady growth. For fiscal year 2010, revenues were [redacted] derived from federal, state and private contracts. The primary focus is on quality service to state Medicaid agencies nationwide and to Medicare in Arizona, California and Florida. HSAG's financial strength is a result of its ability to balance growth and working capital. The company follows generally accepted accounting principles and takes a conservative approach to financial reporting. The company's sound financial status has provided the solid base upon which it has expanded the number and size of contracts awarded.

HSAG is subject to the stringent requirements of the Federal Acquisition Regulation (FAR). As such, HSAG uses an extensive cost accounting system and internal control structure that is in compliance with applicable FAR—Part 31, Contract Cost Principles and Procedures. The company's accounting system and project cost records are audited annually by an external independent certified public accounting firm; audited annually by the Defense Contract Auditing Agency (DCAA), on behalf of the Centers for Medicare & Medicaid Services (CMS); and are also subject to state contract audits. During these audits, in addition to producing required system reports, HSAG prides itself on full disclosure and access to records for these auditors.

Other Clinical and Non-Clinical Skills Necessary to Carry Out EQRO or EQR-related Activities and to Oversee the Work of Any Subcontractors

In addition to the highly skilled clinical and analytical personnel HSAG employs to conduct EQR and EQR-related activities, HSAG employs highly qualified management professionals to lead the organization. HSAG's chief executive officer, Dr. Dalton, brings 30 years of both direct "hands-on" and executive-level experience managing health care projects employing quality management and improvement methods in Medicaid MCOs/PIHPs. Rick Potter, executive vice president, brings more than 20 years of leadership experience in, and knowledge of, health care

quality systems and managed care programs as they relate to performance-based contracting and Medicaid reimbursement systems. Additionally, HSAG's executive team brings extensive administrative, financial, and clinical leadership experience, managing multiple contracts simultaneously for state and federal agencies, managed care plans, hospitals, academic medical centers, and private sector health care companies.

HSAG also employs certified health information and coding personnel to conduct coding reviews. These coders have extensive education and training in anatomy, physiology, pathology, and the disease process, as well as formal training in ICD-9 and CPT/HCPCS coding. The coders are also trained in the reimbursement process for both inpatient and outpatient settings. Coding certifications are then achieved through two nationally recognized organizations, the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC).

OVERSIGHT OF SUBCONTRACTORS

HSAG carefully selects each of its subcontractors to perform specified activities. The strengths of each subcontractor are matched to the particular tasks, and an HSAG project director is assigned to oversee all subcontractor activities and deliverables.

HSAG's intensive oversight and monitoring of its subcontractors ensures a fully integrated, streamlined, and seamless work process. HSAG performs site visits to subcontractor locations as needed and also maintains regularly scheduled contact with its subcontractors during the course of work. For some activities, HSAG holds formal weekly teleconferences to discuss the project's status.

HSAG maintains ultimate oversight and responsibility for all subcontractor activities and deliverables. All communication and deliverables must pass from the subcontractor to HSAG for review and approval before involving the state Medicaid agency.

HSAG INDEPENDENCE

HSAG is independent from the State of West Virginia, the West Virginia Department of Health and Human Resources, and the Bureau for Medical Services.

DISCLOSURE OF PRESENT DIRECT FINANCIAL RELATIONSHIP AND MITIGATION PLAN

HSAG has a current relationship with the Health Plan of the Upper Ohio Valley to perform HEDIS Compliance Audits for their commercial and Medicare product lines. Upon award of the West Virginia EQR contract, HSAG will terminate this contract to avoid any conflict of interest and mitigate the independence requirements as set forth in 42 CFR §438.354.

2.5.5 Vendor must prepare and submit a draft work plan for review and approval by DHHR/BMS within thirty (30) calendar days from the date of contract award. The approved work plan must be submitted to the Bureau for Medical Services, prior to beginning EQR activities.

HSAG will prepare and submit a draft work plan for review and approval by DHHR/BMS within 30 calendar days from the date of contract award. HSAG understands that the approved work plan must be submitted to BMS prior to beginning EQR activities.

2.5.6 Vendor's project manager or a designated representative shall attend all quarterly meetings of the MHT Task Force.

HSAG's West Virginia Project Lead, Debra Chotkevys (as well as other staff members who may be required), shall attend all quarterly meetings of the MHT Task Force.

2.5.7 The Vendor will provide quarterly written status reports to Bureau for Medical Services within fifteen (15) calendar days of end of quarter.

HSAG will provide quarterly written status reports to BMS within 15 calendar days of the end of the quarter. HSAG has extensive experience providing various types of status reports, which are a contract requirement of most of its clients, including state Medicaid agencies and CMS. HSAG will work with BMS to develop a concise and user-friendly template for the quarterly status report that will outline for each activity, the accomplishments over the previous month, the goals for the upcoming month, and any outstanding issues that have been identified.

2.5.8 The Vendor shall provide additional services to comply with externally driven changes to BMS programs and requirements, including any State or Federal laws, rules, and regulations. Additional Services shall be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work (SOW) and submission of related Cost Estimate.

HSAG will provide additional services to comply with externally driven changes to BMS programs and requirements, including any State or federal laws, rules, and regulations. Additional services shall be bid as an all-inclusive hourly rate. HSAG understands that this bid will require BMS approval of a statement of work and submission of related cost estimate.

HSAG's Abilities and Experience Over and Above Standard EQRO Services

HSAG has provided a wide array of additional services over and above the standard EQRO services in the following areas:

- **Research and Technical Expertise**

- **Technical Assistance on Enrollee Race/Ethnicity and Primary Household Language Information**, conducting a thorough review of current practices and procedures for collecting and transmitting race/ethnicity and primary language of Medicaid enrollees. Based upon the findings from this review, HSAG provides specific recommendations to states to ensure compliance with BBA requirements.
- **Research and Literature Review of Quality Standards for Medicaid Encounter Data**

  ODJFS requested technical assistance from HSAG to complete a review on Encounter Data Omission quality standards. HSAG researched the Web sites for all 50 states to determine their experiences with both setting and reporting validity levels consistent with either The Medstat Group's criteria or the newer CMS criteria. Only Web sites for Arizona, Colorado, Iowa, New York, Texas, Vermont, and Washington State contained readily available and relevant information. This review found that there was very little information on predetermined levels for encounter data validity was readily available on states' Web sites. The information gathered suggested that states have a wide range of requirements and a wider range of results, both of which are quite divergent from the CMS guidelines.

- **Encounter Data Validation (EDV)** for managed care plans. The purpose of the EDV analysis is to provide a baseline assessment of the MCO encounter data, to determine the accuracy of encounter data compared to the medical record, to determine the completeness of the MCO and State encounter data, and to provide recommendations to improve processes associated with the collection and submission of encounter data. HSAG bases its EDV efforts on the protocol for validating encounter data published by CMS.
- **Focused Quality of Care Studies**. Each study is designed to include a thorough literature review, a study question, study goals, sampling methodology, review methodology, study limitations, study tools, data analysis plan, and data reporting plan.
- **Readiness Reviews** for new plans that enter the program. The Readiness Review assesses the new MCP for compliance with the state's contract. HSAG determines prior to enrollment whether each new MCP's internal monitoring processes are sufficient for assuring ongoing compliance with contract requirements, quality oversight, and monitoring of the Quality Assurance Plan (QAP).
- **Overall Evaluation of the Quality Strategy.** As specified in 42 CFR 483.202, the state is required to conduct a periodic review to evaluate the overall effectiveness of the State's Quality Review Strategy for Managed Care (Quality Strategy) and to make revisions periodically, as needed. HSAG reviews the Quality Strategy for compliance with the requirements of 42 CFR 438.204. On an annual basis, HSAG makes recommendations to the state on the effectiveness of its Quality Strategy. This includes HSAG's participation in an annual quality assurance meeting to review the Quality Strategy with stakeholders, providers, and managed care organizations.

I certify that the proposal submitted meets or exceeds all the mandatory specifications of this RFP. Additionally, I agree to provide any additional documentation deemed necessary by the Bureau to demonstrate compliance with said mandatory specifications.

Health Services Advisory Group, Inc.
(Company)

Mary Ellen Dalton CEO
(Representative Name, Title)

602.264.6382 / 602.241.0757
(Contact Phone/Fax Number)

2-27-12
(Date)

Attachment D: Special Terms and Conditions

As instructed in the RFP, HSAG has included the signed Attachment D: Special Terms and Conditions in both Attachment B (item 2.5.1) and Attachment D.

Attachment D: Special Terms and Conditions

If a Vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.

Agree that BMS retains ownership of all data, procedures, programs, workpapers and all materials gathered or developed under the contract with West Virginia.

I certify that I have acknowledged the additional contract provisions contained in Attachment D and that the proposal meets or exceeds all additional requirements as listed.

Health Services Advisory Group, Inc.
(Company)

Mary Ellen Dalton, CEO
(Representative Name, Title)

602.264.6382 / 602.241.0757
(Contact Phone/Fax Number)

2-27-12
(Date)

Attachment C: Cost Sheet

As instructed in the RFP, HSAG has included Attachment C: Cost Sheet in its Cost Proposal. As instructed, it is in a separate sealed envelope, clearly marked.

Attachment D: Special Terms and Conditions

If a Vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.

Agree that BMS retains ownership of all data, procedures, programs, workpapers and all materials gathered or developed under the contract with West Virginia.

I certify that I have acknowledged the additional contract provisions contained in Attachment D and that the proposal meets or exceeds all additional requirements as listed.

Health Services Advisory Group, Inc.
(Company)

Mary Ellen Dalton, CEO
(Representative Name, Title)

602.264.6382 / 602.241.0757
(Contact Phone/Fax Number)

2-27-12
(Date)

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED12009	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	SHIP TO
Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. TO ANSWER VENDOR QUESTIONS AS PER THE ATTACHED.
2. TO MODIFY THE RFP PER THE ATTACHED.
3. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED12009

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 x
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mary Ellen Dalton	602.264.6382	2-27-12
TITLE Chief Executive Officer	FEIN 86-0440007	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED12009	2

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR
Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501

SHIP TO
BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

Mary Ellen Dalton
SIGNATURE

Health Services Advisory Group, Inc.
COMPANY

2-27-12
DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mary Ellen Dalton	602.264.6382	2-27-12
TITLE: Chief Executive Officer	FEIN: 86-0440007	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

RFQ No. MED12009

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Health Services Advisory Group, Inc.

Authorized Signature: MaryEllen Dalton Date: 2-27-12

State of Arizona

County of Maricopa, to-wit:

Taken, subscribed, and sworn to before me this day of Feb. 27, 2012

My Commission expires Nov. 5, 2014.

AFFIX SEAL HERE

OFFICIAL SEAL
REBA H. PALMATIER
Notary Public - State of Arizona
MARICOPA COUNTY
My Comm. Expires Nov. 5, 2014

NOTORY PUBLIC Reba H. Palmatier

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

Health Services Advisory Group

fulfilled all the necessary requirements
to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-LICENSED ORGANIZATION

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2011	10/31/2012
DATE LICENSED	EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group, Inc.

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

SURVEY VENDOR
NCQA
CERTIFIED

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2011
DATE GRANTED

October 31, 2012
EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group, Inc.

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2011
DATE GRANTED

October 31, 2012
EXPIRATION DATE

Certificate Number: U090014R-1329

urac

CERTIFICATE OF FULL ACCREDITATION

is awarded to

Health Services Advisory Group, Inc.

1600 East Northern Ave. Suite 100, Phoenix, AZ, 85020

for compliance with

Health Utilization Management Accreditation Program

pursuant to the

Health Utilization Management , Version 6.0

Effective from the 1st day of December of 2009 through the 1st of December of 2012

Alan P. Spielman
President & CEO

Christine Leyden, RN, MSN
Chief Accreditation Officer

URAC

ACCREDITED

Health Utilization Management

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

State of Hawaii

Department of Human Services

Med-QUEST Division

2011 External Quality Review Report of Results *for the* QUEST and QUEST Expanded Access Health Plans

November 2011

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

Contents

1. Executive Summary 1-1
Overview 1-1
External Quality Review Activities, Conclusions, and Recommendations 1-2
Compliance Monitoring Review of Structure and Operations Standards 1-2
Validation of Performance Measures—HEDIS Compliance Audits 1-3
Validation of Performance Improvement Projects 1-7
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey 1-8
Provider Survey 1-13
How This Report Is Organized 1-15
2. Overview 2-1
Overview of the Hawaii Medicaid Service Delivery System 2-1
The Hawaii Medicaid Program 2-1
The QUEST Health Plans 2-2
The QUEST Expanded Access (QExA) Health Plans 2-2
The State's Quality Strategy 2-3
3. Plan-Specific Results, Conclusions, and Recommendations 3-1
Introduction 3-1
Compliance Monitoring Review 3-2
Validation of Performance Measures—HEDIS Compliance Audits 3-10
Validation of Performance Improvement Projects 3-37
Consumer Assessment of Healthcare Providers and Systems (CAHPS)-Child Survey 3-55
Provider Survey 3-71
Overall Conclusions and Recommendations for Each Health Plan 3-97
4. Health Plan Comparison by EQR Activity 4-1
Introduction 4-1
Health Plan Comparison 4-1
Compliance Monitoring Review 4-1
Validation of Performance Measures—HEDIS Compliance Audits 4-2
Validation of Performance Improvement Projects 4-28
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey 4-32
Provider Survey 4-38
5. Assessment of Follow-up to Prior Year Recommendations 5-1
Introduction 5-1
Compliance Monitoring Review 5-1
Validation of Performance Measures—HEDIS Compliance Audits 5-4
Validation of Performance Improvement Projects 5-18
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey 5-25
Appendix A. Methodologies for Conducting EQR Activities A-1
Compliance Monitoring Review A-2
Validation of Performance Measures—HEDIS Compliance Audits A-4
Validation of Performance Improvement Projects A-7
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey A-10
Provider Survey A-13

Overview

The 2011 Hawaii External Quality Review Report of Results for the QUEST and QUEST Expanded Access (QExA) Health Plans is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG) is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), which is responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the three QUEST health plans and two QExA health plans. The QUEST health plans were AlohaCare QUEST (AlohaCare), Hawaii Medical Service Association QUEST (HMSA), and Kaiser Permanente Hawaii QUEST (Kaiser). The QExA plans were Evercare QExA (Evercare) and 'Ohana Health Plan QExA (Ohana).

HSAG's external quality review (EQR) of the health plans included directly performing the three federally mandated activities as set forth in 42 CFR 438.358—a review and evaluation of compliance with the federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] compliance audits, and validation of performance improvement projects (PIPs). Two optional EQR activities were also performed this year: a survey of child members (e.g., parents/caregivers) using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®),[1-2] and a survey of health care providers (primary care providers and specialists) contracted with the QUEST and QExA health plans.

This report includes the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each health plan, as well as plan comparative information, is included. Where applicable, the report discusses the status of improvement activities. It also offers recommendations for improving the quality and timeliness of, and access to, health care services provided by each health plan.

This is the seventh year HSAG has produced the EQR report of results for the State of Hawaii. Report information does not disclose the identity of any patient, in accordance with 42 CFR 438.364(c).

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

External Quality Review Activities, Conclusions, and Recommendations

HSAG, as the EQRO for the MQD, conducted EQR activities and analyzed the results as described in the next sections of this report. HSAG also offered conclusions and recommendations for improvement to the five Hawaii Medicaid health plans.

Compliance Monitoring Review of Structure and Operations Standards

Description

For the 2011 evaluation of health plan compliance, HSAG developed a monitoring tool to document pertinent findings and to calculate performance scores in five areas, or standards. These standards were related to the health plans' structure and operations, as described in the managed care regulations in the Code of Federal Regulations (CFR), Subpart D (42 CFR 438.214–230). This review included approximately half of the managed care regulations and associated State standards to be reviewed within a three-year period, as the other half of the standards and requirements had been reviewed in 2010.

Findings, Conclusions, and Recommendations

The QUEST and QExA health plans received individual scores for each of the five standard areas reviewed for compliance and an overall total score. The following table illustrates each plan's performance on each standard, each plan's total compliance score, and a statewide score by standard and for the five plans overall.

Table 1-1—Standards and Compliance Scores

Standard #	Standard Name	AlohaCare QUEST	HMSA QUEST	Kaiser QUEST	Evercare QExA	Ohana QExA	Statewide Score
I	Delegation	**77**	**100**	**NA***	**91**	**100**	**92**
II	Member Information	**94**	**92**	**95**	**91**	**98**	**94**
III	Grievance System	**72**	**76**	**62**	**79**	**95**	**77**
IV	Provider Selection	**100**	**100**	**100**	**100**	**100**	**100**
V	Credentialing	**96**	**98**	**100****	**25**	**93**	**83**
	Total Compliance Score:	**89**	**92**	**89**	**64**	**96**	**86**

*Kaiser was not reviewed for this standard, as it did not delegate any managed care functions for its Medicaid program.
**Kaiser was "deemed" compliant for credentialing, as it had attained 100 percent compliance in its NCQA accreditation review.

Two areas of strong health plan performance statewide emerged: member information (all plans scored above 90 percent) and provider selection (all plans achieved 100 percent). This demonstrated that the plans had processes and documentation in place to ensure enrolled members received the required information about accessing covered services and about other health plan operations, and that the plans had procedural mechanisms and the required provider agreement language for selecting and contracting with their provider network.

Two other areas of strength for four of the five health plans were delegation and credentialing. For delegation, all plans except AlohaCare scored above 90 percent. This standard measured the degree to which health plans had mechanisms in place to meet requirements for contracting with and overseeing any delegated health plan activities. Credentialing was also an area of strong performance for four of the five health plans, with scores of 90 percent or higher for all plans except Evercare. The State had adopted the NCQA standards as its credentialing policy, and the health plans were reviewed for their policies, procedures, and practices related to these credentialing requirements.

Except for Ohana, with a score of 95 percent, all the health plans scored below 80 percent and had several opportunities for improvement in the area of grievance system. Overall, this standard was the weakest performance area. Numerous required actions and recommendations were provided to the plans to ensure performance improvement related to the health plan's policies, procedures, and practices for receiving and responding to grievances and appeals received from members and/or providers.

Following issuance of the final reports of this activity, the health plans were required by the MQD to submit corrective action plans (CAPs) for any standards scored *Partially Met* or *Not Met*. HSAG collaborated with the MQD to review and approve the health plans' CAPs and will continue to review the plans' implementation of their approved corrective actions to ensure that full compliance is achieved. The results of this follow-up CAP activity and reevaluation of compliance will be reported in next year's EQR results report.

Validation of Performance Measures—HEDIS Compliance Audits

Description

HSAG performed independent audits of the HEDIS data for the three QUEST and two QExA health plans consistent with the *2011 NCQA HEDIS Compliance Audit™ Standards, Policies, and Procedures, HEDIS Volume 5*. Each HEDIS Compliance Audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures.

During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS performance measures. The six measures reviewed were: *Childhood Immunization Status, Comprehensive Diabetes Care, Ambulatory Care, Cholesterol Management for Patients With*

™ NCQA HEDIS Compliance Audit is a trademark of the National Committee for Quality Assurance (NCQA).

Cardiovascular Conditions, *Breast Cancer Screening*, and *Chlamydia Screening in Women*. The measurement period was calendar year (CY) 2010 (January 1, 2010, through December 31, 2010) and the audit activities were conducted concurrently with HEDIS 2011 reporting.

Findings, Conclusions, and Recommendations

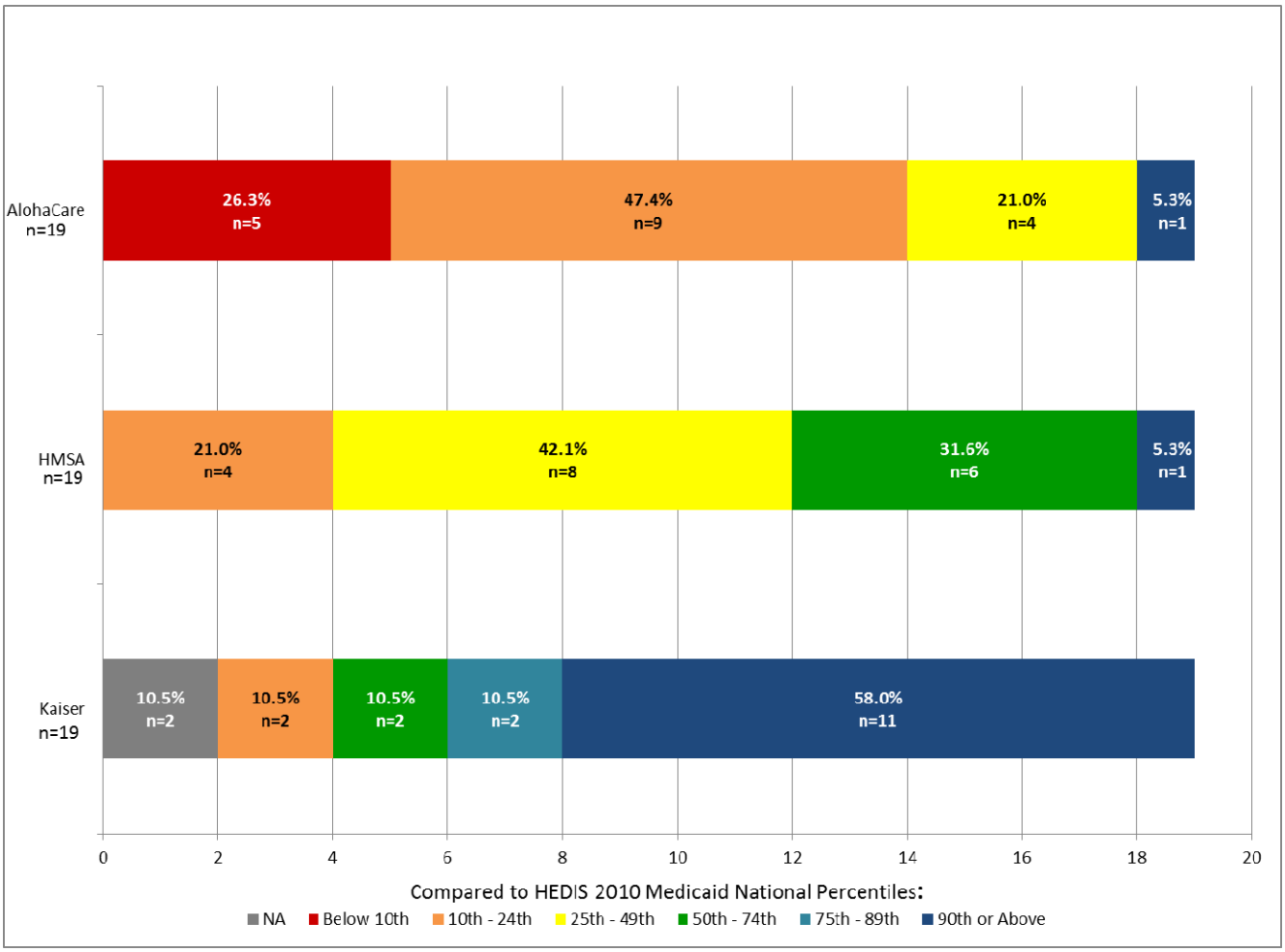
HSAG evaluated each health plan's compliance with the National Committee for Quality Assurance's (NCQA's) IS standards and found that all five plans were fully compliant with all standards.

All plans except Kaiser used NCQA-Certified software to generate the HEDIS measures. Kaiser calculated the required measures using internally developed programming code. Most plans used supplemental pharmacy and lab data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

When calculating HEDIS performance measure rates, the QExA health plans excluded members who were dually eligible (i.e., members with both Medicaid and Medicare coverage) when their Medicare coverage was through fee-for-service Medicare or an unknown/other Medicare plan. This approach was consistent with the HEDIS technical specifications. Because data on Medicare services and encounters would not be readily available to the plans, eliminating this dually-eligible population from the measure calculations reduced the chance of negatively impacting the performance measure results. However, dually-eligible members enrolled in a plan's Medicaid program and Medicare Advantage (MA) plan were expected to be included in the rate calculations.

HSAG analyzed the performance measure results separately for the QUEST and QExA plans because of differences in the populations served. For each performance measure indicator, HSAG compared the results to the national Medicaid HEDIS 2010 means and percentiles. Figure 1-1 displays the results for the QUEST plans. The "n" in the following figures indicates the number of indicators in the plans' performance measures that fell within the designated percentile range compared to the HEDIS 2010 national Medicaid percentiles. Rates representing a population that was too small for reporting purposes were referred to as "*Not Applicable*" or *NA*, and were not included in the performance calculations.

Figure 1-1—Comparison of QUEST Plan Indicators to HEDIS Medicaid National Percentiles

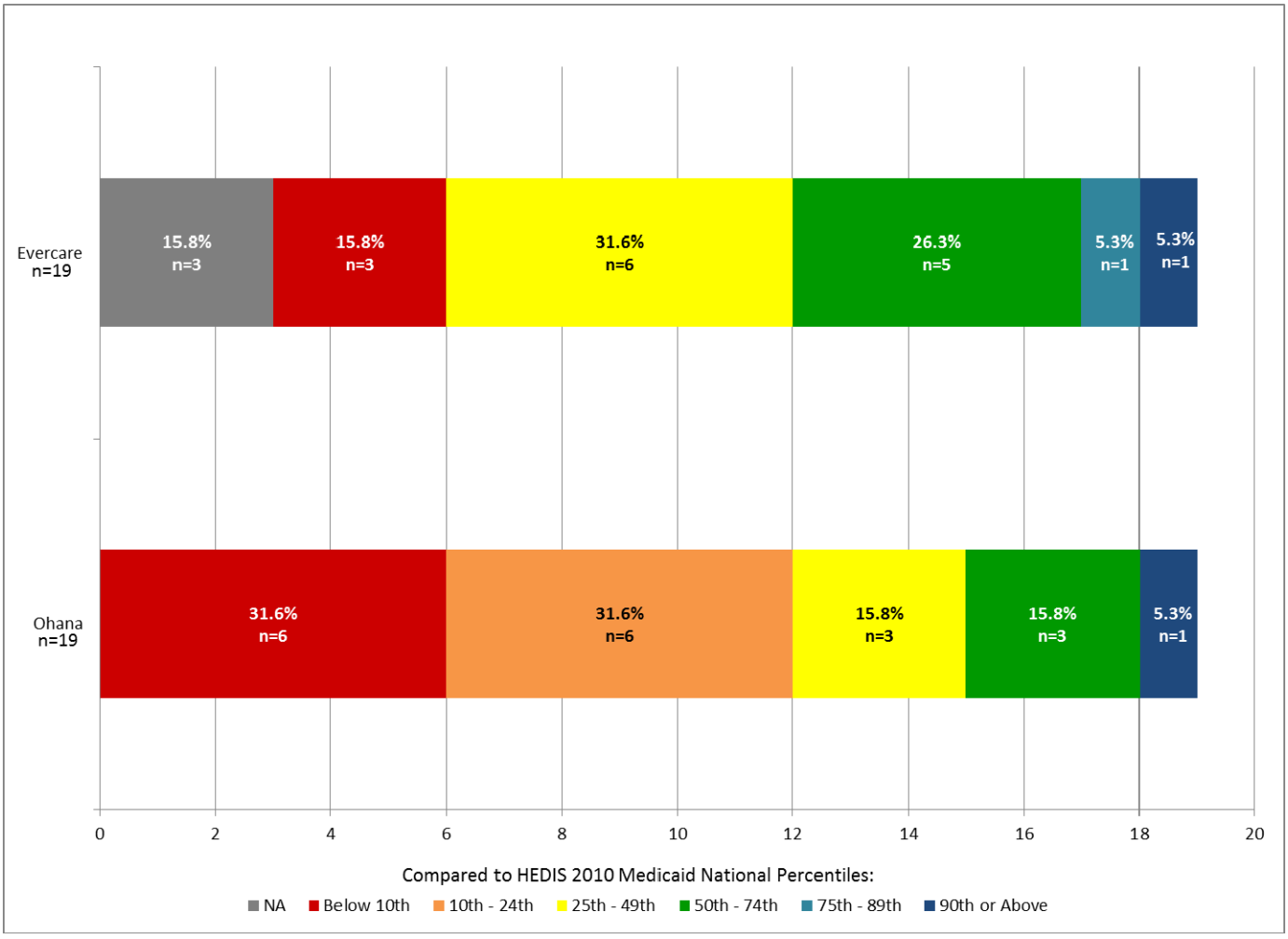


HSAG validated six performance measures for HEDIS 2011, which resulted in a total of 19 separate indicator rates being reported across all audited measures. The QUEST plans were able to report all 19 indicators, except Kaiser, which had two indicators with populations too small to report valid rates, and therefore, received *NA* (or *Not Applicable*) audit results for those measures.

The QUEST plans were diverse in their performance. Kaiser reported 76.5 percent of its indicators (13 of 17) at or above the HEDIS 2010 national Medicaid 75th percentile (the MQD Quality Strategy target). In addition, 64.7 percent of the indicators (11 of 17) were at or above the HEDIS 2010 national Medicaid 90th percentile. HSAG noted that HMSA had moderate performance, reporting 36.8 percent (7 of 19) of its indicators at or above the HEDIS 2010 national 50th percentile, and only one indicator above the MQD Quality Strategy target of the 75th percentile. AlohaCare's performance was the poorest of the QUEST plans, with the plan reporting only one indicator above the HEDIS 2010 national Medicaid 75th percentile. Of AlohaCare's measures, 47.4 percent (or 9 of the 19 indicators) were reported in the 10th-to-24th-percentile range and 26.3 percent (or 5 of the 19 indicators) reported at or below the 10th percentile. While ranking and comparing the health plans on the basis of HEDIS Medicaid national percentiles is useful, information about the plans' unique member demographics and delivery model should also be considered when assessing performance differences.

Figure 1-2 shows the QExA plans' performance compared with the national percentiles. Since QExA members represent the Medicaid aged, blind, and disabled population, caution should be used when comparing the results to national Medicaid percentiles.

Figure 1-2—Comparison of QExA Plan Indicators to HEDIS Medicaid National Percentiles



HSAG validated six measures for the QExA plans, which resulted in 19 indicator rates. Performance between the two QExA plans varied. Evercare was the better performing QExA plan with seven of the 16 reportable indicators (or 43.8 percent) at or above the HEDIS 2010 national 50th percentile compared to Ohana, which reported four of the 19 indicators (or 21.1 percent) at or above the HEDIS 2010 national 50th percentile. Evercare had three audited performance indicators with populations too small to report valid rates; therefore, the plan received NA (or Not Applicable) audit results for those measures. When comparing performance to the MQD Quality Strategy target, Evercare reported two indicators above the national Medicaid 75th percentile and Ohana reported only one.

Recommendations for improvement varied across the indicators. HSAG recommends that each QUEST and QExA plan target the lower-performing measures/indicators for improvement. Each

plan should conduct a barrier analysis to determine why performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases. Within Section 3 of this report, HSAG offers measure-specific intervention activities that should be considered to improve performance.

Validation of Performance Improvement Projects

Description

PIPs are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2011, HSAG validated two PIPs for each of the QUEST and QExA health plans. The QUEST plans were required by the MQD to conduct PIPs on the topics, *Access to Care* and *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form.* The QExA plans were required to conduct one PIP on improving the results of a HEDIS measure, and a second PIP on a topic of the plan's choice, approved by the MQD. Both QExA plans conducted PIPs related to the HEDIS measure on diabetes care. For their second PIP topic, both QExA plans focused on an aspect of obesity care.

HSAG validated each QUEST and QExA plan's PIPs by following standardized validation procedures, assessing the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. This process facilitates improvements in care and generates confidence that reported improvement has, in fact, been accomplished.

Findings, Conclusions, and Recommendations

Following the review and validation of the plans' 2011 PIPs, HSAG concluded that:

- All six PIPs conducted by the three QUEST plans (AlohaCare, HMSA, and Kaiser) received a *Met* validation status. This rating indicated high confidence that the PIPs were valid and the results were credible.
- The QUEST plans performed well in the Design and Implementation stages of their respective PIPs. The plans performed lowest in the Outcomes stage of their PIPs.
- HMSA and Kaiser demonstrated success with their BMI-related PIPs, as three of the four study indicators showed statistically significant improvement. AlohaCare had demonstrated improvement for one of its BMI-related PIP indicators.
- For the QUEST plans' access-related PIPs, AlohaCare did not show real (statistically significant) change or improvement for any of its four indicators. Kaiser also had no real change for its one access to care indicator. However, HMSA did demonstrate statistically significant improvement for its access indicator.
- Three of the four PIPs conducted by the QExA plans received a *Met* validation status. This rating indicated high confidence that the PIPs were valid and the results were credible.
- Ohana's obesity PIP received a *Not Met* validation status, indicating no confidence in the validity of this PIP.
- Evercare performed well in the Design and Implementation stages for both of its PIPs.

- Ohana's performance in the Design and Implementation stages was mixed, with one PIP (obesity) lacking documentation for sampling techniques, data collection processes, and accurate reporting of results.
- Neither Evercare's nor Ohana's PIPs had progressed to the point of reporting study outcomes or being assessed for improvement.

The health plans received various recommendations on their PIPs, including improving PIP documentation. Additional recommendations addressed specific measures to increase the plans' likelihood of effecting real and sustained improvement in their PIPs, such as conducting a causal/barrier analysis when improvement did not result from their interventions or when a decline in improvement occurred upon remeasurement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

Description

The CAHPS health plan surveys are standardized survey instruments that measure members' satisfaction levels with their health care. For 2011, HSAG administered the CAHPS 4.0H Child Medicaid Health Plan Survey to members of the QUEST and QExA plans under 18 years of age. Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan CAHPS data.

The results of nine measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*).

Findings, Conclusions, and Recommendations

For the QUEST plans and the statewide QUEST aggregate scores as compared to the 2010 NCQA national child Medicaid average, the following results were noted:

- The QUEST aggregate score was above the NCQA national child Medicaid average on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- AlohaCare scored above the NCQA national child Medicaid average on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- HMSA scored above the NCQA national child Medicaid average on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Shared Decision Making*.
- Kaiser scored above the NCQA national child Medicaid average on seven measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

Figure 1-3 depicts the top-box scores for the statewide QUEST aggregate and the 2010 NCQA national child Medicaid average for each of the global ratings.

Figure 1-3—QUEST Aggregate: Global Ratings

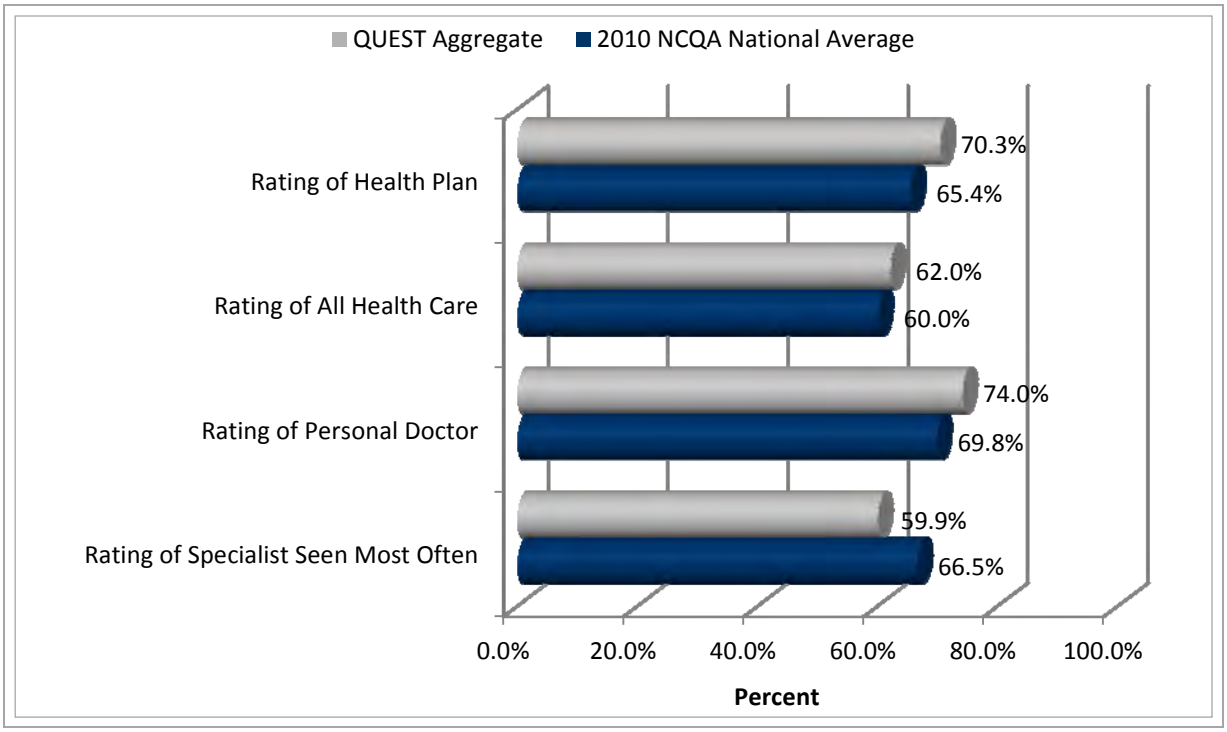
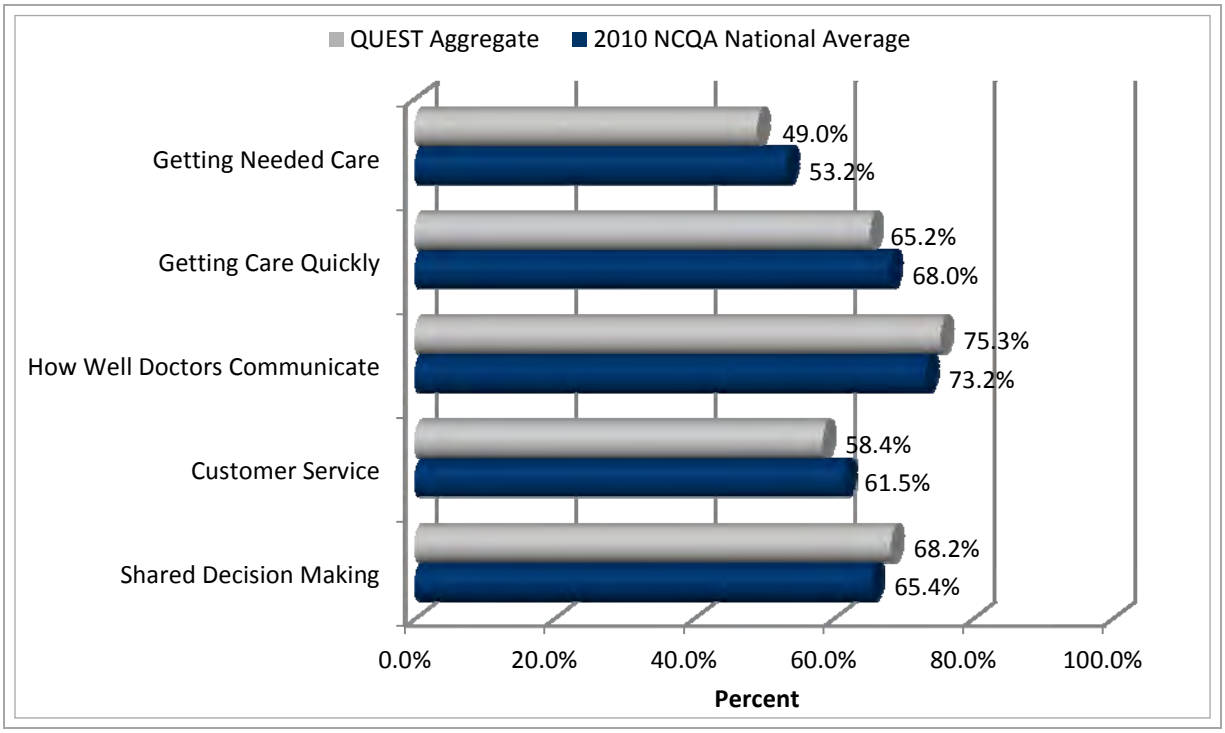


Figure 1-4 depicts the top-box scores for the statewide QUEST aggregate and the 2010 NCQA national child Medicaid average for each of the composite measures.

Figure 1-4—QUEST Aggregate: Composite Measures



For the QExA plans and the statewide QExA aggregate scores as compared to the 2010 NCQA national child Medicaid average, the following results were noted:

- The QExA aggregate score was above the NCQA national child Medicaid average on one measure: *Shared Decision Making*.
- Evercare scored above the NCQA national child Medicaid average on four measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- Ohana scored above the NCQA national child Medicaid average on one measure: *Shared Decision Making*.

Figure 1-5 depicts the top-box scores for the statewide QExA aggregate and the 2010 NCQA national child Medicaid average for each of the global ratings.

Figure 1-5—QExA Aggregate: Global Ratings

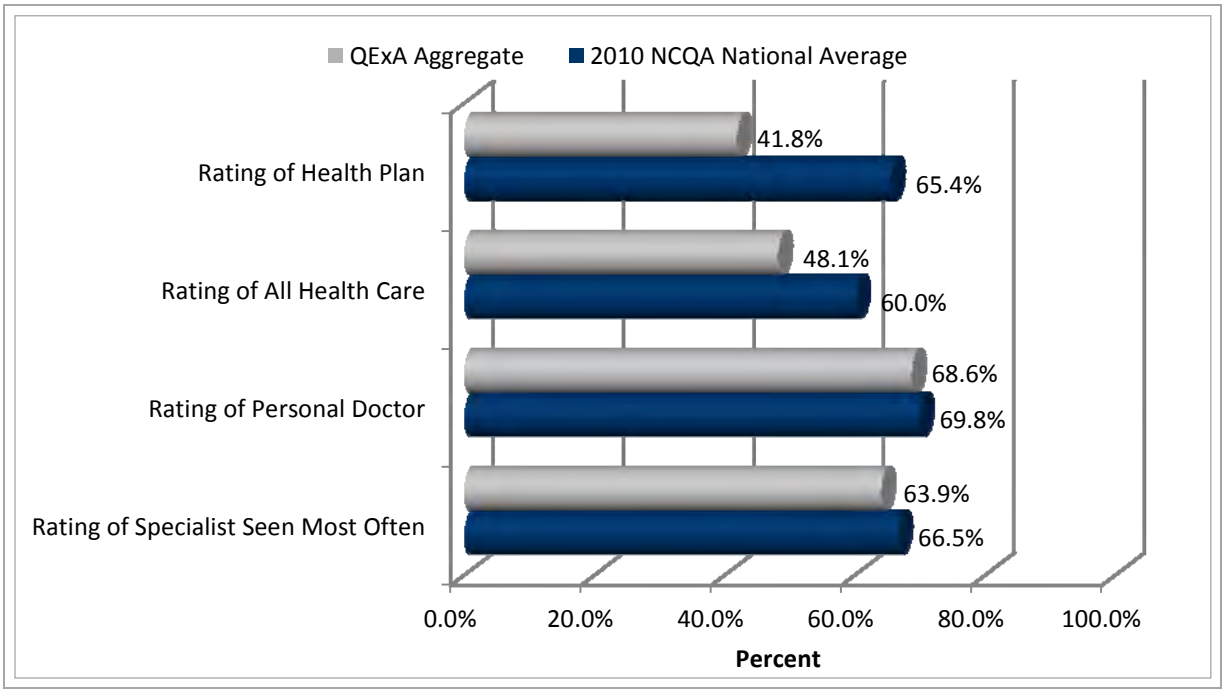
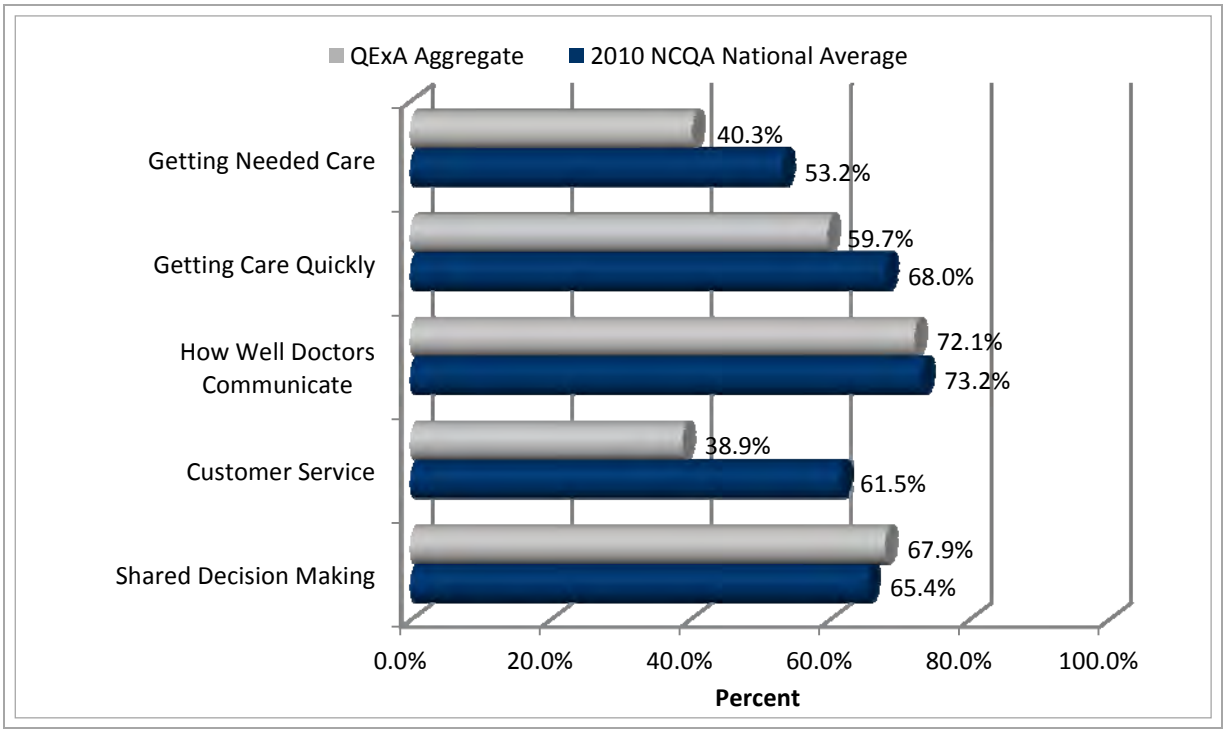


Figure 1-6 depicts the top-box scores for the statewide QExA aggregate and the 2010 NCQA national child Medicaid average for each of the composite measures.

Figure 1-6—QExA Aggregate: Composite Measures



The QUEST and QExA health plans received recommendations related to these findings for each of the measures that were considered to be "key drivers" of member satisfaction for the plan.

.

Provider Survey

Description

In 2011, HSAG administered surveys to health care providers who served Medicaid members through one or more QUEST or QExA health plans. The goal of the provider survey was to supply feedback to the MQD as it relates to providers' perceptions of the QUEST and QExA health plans and the Med-QUEST program. The survey covered topics for primary care and specialty providers, including impact of the plans' utilization management on the providers' abilities to provide quality care, satisfaction with reimbursement, and adequacy of the formulary. A total of 1,500 providers were randomly sampled for inclusion in the survey administration which occurred from April to June 2011. Results were compiled and analyzed separately for the QUEST plans and for the QExA plans, noting statistically significant differences for each plan as compared to the performance of the comparative plan(s). For the QUEST plans only, the results also noted whether there were statistically significant improvements or declines in provider satisfaction as compared to their results when the survey was last administered in 2009. As this was the first survey of providers for the QExA plans, no trending could be performed.

Findings, Conclusions, and Recommendations

The following is a summary of the QUEST plans' performance on the 16 measures evaluated for statistical differences:

- AlohaCare's performance was significantly lower than the aggregate performance of the other plans on all 16 measures.
- HMSA's performance was significantly higher than the aggregate performance of the other plans on two measures and significantly lower than the aggregate performance of the other plans on seven measures.
- Kaiser's performance was significantly higher than the aggregate performance of the other plans on 15 measures.

Comparison of the QUEST plans' 2011 rates to their corresponding 2009 rates on the 14 measures evaluated for statistically significant differences revealed the following summary results:

- AlohaCare scored significantly higher in 2011 than in 2009 on one measure: referral process.
- HMSA scored significantly higher in 2011 than in 2009 on eight measures: compensation satisfaction, knowledge, keep informed, adequacy of specialists, prior authorization process, referral process, formulary, and concurrent review.
- Kaiser scored significantly higher in 2011 than in 2009 on seven measures: knowledge, adequacy of specialists, range of specialists, referral process, formulary, concurrent review, and discharge planning.
- None of the QUEST plans scored significantly lower in 2011 than in 2009 on any of the measures.

The following is a summary of the QExA plans' performance on the 16 measures evaluated for statistical differences:

- Evercare's performance was significantly lower than the performance of the other plans (Ohana and commercial managed care health plans) on the two General Positions measures.
- Ohana's performance was not significantly different from comparative populations' performance on any of the measures.

Since the provider survey revealed that there was an opportunity to improve provider satisfaction related to both the QUEST and QExA health plans, HSAG provided recommendations for improving provider satisfaction within the domains evaluated. Recommendations for the MQD related to the administration of the survey were also offered.

How This Report Is Organized

This Executive Summary presents a high-level overview of the 2011 EQR activities, results, and recommendations for the Hawaii Medicaid program's QUEST and QExA health plans. For more detailed information, the remaining sections of this report provide the following:

Section 2, Overview, gives a description of Medicaid in Hawaii, brief descriptions of each of the five health plans that contract with the MQD to provide services to eligible, enrolled members, and a brief overview of the State's quality strategy.

Section 3, Plan-Specific Results, Conclusions, and Recommendations, includes the specific EQR activity results for each of the five health plans, assessments of the plans' strengths and weaknesses, and HSAG's recommendations for improving the health plans' performance and the quality and timeliness of, and access to, care and services provided to enrolled members.

Section 4, Health Plan Comparison by EQR Activity, presents comparative information about the plans' performance and results. When methodologically appropriate, comparisons are also made to statewide averages or national benchmarks.

Section 5, Assessment of Follow-Up to Prior Year Recommendations, provides information on follow-up actions taken by each of the plans based on the results of the 2010 EQR activities conducted and recommendations made by HSAG.

In **Appendix A: Methodologies for Conducting EQR Activities**, the methodologies HSAG used for conducting each of the five EQR activities are described in detail, including each activity's objectives, technical methods of data collection and analysis, and description of the data obtained.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers nearly 270,000[2-1] individuals in the State of Hawaii. The MQD, the division of the Department of Human Services responsible for the overall administration of the State's Medicaid managed care program, has as its mission statement, "To develop and administer high-quality health care programs serving all eligible Hawaii residents." The Hawaii QUEST program is designed to provide:

Q uality care, ensuring
U niversal access, encouraging
E fficient utilization,
S tabilizing costs, and
T ransforming the way health care is provided to public clients.

Hawaii's Medicaid program employs two main program types for the delivery of health care services to two major groups of Medicaid recipients in the State. Most Medicaid recipients, over 220,000 individuals, receive primary and acute care service coverage through the Hawaii QUEST program, a primary and acute services managed care model operating under an 1115 research and demonstration waiver since 1994. The QUEST population (largely composed of pregnant women and children) also includes the State's Child Health Insurance Program (CHIP) population as a Medicaid expansion program. Since February 1, 2009, Medicaid-eligible individuals 65 years of age and older and individuals certified as blind or disabled were enrolled in Hawaii's QExA Medicaid managed care program, receiving primary and acute services as well as long-term care services and supports. Numbering approximately 42,000 individuals, these recipients previously were enrolled in the State's fee-for-service (FFS) program. A very small number of Medicaid recipients remain in the State's FFS "window" at any given time.

In 2011, eligible QUEST recipients received covered health care and services through one of three State-contracted QUEST health plans: AlohaCare, HMSA, and Kaiser. Recipients eligible for and enrolled in the QExA program received covered services through one of two QExA health plans: Evercare and Ohana. While each of the QUEST and QExA health plans also has at least one other line of health insurance business (e.g., Medicare, commercial), the focus of this report is on performance and outcomes for the Medicaid-eligible population.

Medicaid recipients live on six of the islands which constitute the State of Hawaii, a demographic that presents unique challenges to providing access to care and services. Except for the small islands

[2-1] All Medicaid enrollment statistics cited in this section are as of June, 2011. Available at http://www.med-quest.us/ManagedCare/MQDquestenroll.html Accessed on October 14, 2011.

of Molokai and Lanai, Hawaii's Medicaid program gives eligible members a choice of at least two managed care health plans on each island.

The QUEST Health Plans

AlohaCare

AlohaCare is a nonprofit health plan founded in 1994 by Hawaii's community health centers. As one of the largest health plans in Hawaii, and administering both Medicaid and Medicare health plan products, AlohaCare QUEST serves over 75,000 Medicaid enrollees. AlohaCare contracts with a large network of providers statewide, emphasizing prevention and primary care. AlohaCare works closely with fourteen community health centers to support the needs of the underserved, medically fragile members of Hawaii's communities on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

Hawaii Medical Service Association (HMSA)

HMSA, an independent licensee of the Blue Cross and Blue Shield Association, is a nonprofit health plan established in Hawaii in 1938. Administering Medicaid, Medicare, and commercial health plans, HMSA is the largest provider of health care coverage in the State, and the largest QUEST plan, serving over 119,000 enrolled Medicaid members. More than 95 percent of Hawaii's doctors, hospitals, and other providers participate in HMSA's network. HMSA has been a Medicaid contracted health plan since 1994, and currently serves Medicaid members on the islands of Hawaii, Kauai, Maui, and Oahu.

Kaiser Permanente Hawaii

Established by Henry J. Kaiser in Honolulu in 1958, Kaiser's service delivery in the Hawaii region is based on a relationship between the Kaiser Permanente Health Plan and the Hawaii Permanente Medical Group of physicians and specialists. With its largely "staff-model" approach, Kaiser operates clinics throughout the islands and a medical center on Oahu. Additional hospitals and specialists participate in Kaiser's network through contract arrangements. Kaiser administers Medicaid, Medicare, and commercial health plans, and provides care to about 27,000 enrolled Medicaid members on the islands of Maui and Oahu.

The QUEST Expanded Access (QExA) Health Plans

Evercare

Evercare is offered by United Healthcare Insurance Company and is one of two plans awarded a contract to participate in the QExA program. Evercare administers Medicaid, Medicare, and commercial health plans, and provides care to about 20,000 aged, blind, and disabled Medicaid enrollees. Evercare QExA began operating in Hawaii and providing services to Medicaid long-term care recipients on February 1, 2009, on the islands of Hawaii, Kauai, Maui, and Oahu.

Ohana

Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc., a subsidiary of WellCare Health Plans, Inc., which provides managed care services exclusively for government-sponsored health care programs, focusing on Medicaid and Medicare. Ohana Health Plan is one of two plans awarded a contract to participate in the QExA program, and currently provides services to about 23,000 aged, blind, and disabled Medicaid enrollees. Ohana QExA began operating in Hawaii on February 1, 2009, and provides services on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

The State's Quality Strategy

In 2010, the MQD had developed, and CMS approved, a new and comprehensive quality strategy for the State's Medicaid program that incorporated the Institute of Medicine (IOM) quality framework for safe, efficient, effective, patient-centered, timely, and equitable care. This quality strategy continued to be in effect during 2011. The strategy contains guiding principles for ensuring a high-quality care delivery system that includes collaborative partnerships, patient-centered medical homes, transparency, data-driven analysis and monitoring, and quality-based purchasing. In keeping with these principles, this 2011 Hawaii External Quality Review Report of Results provides data analysis, outcomes of monitoring, a mechanism for public reporting and transparency, and validated health plan performance information that the MQD and the health plans can use to further the State's quality strategy goals.

Examples of initiatives undertaken by the MQD as part of this quality strategy over the past year include:

- Including optional as well as mandatory activities in HSAG's scope of work as EQRO for the State of Hawaii Medicaid program: compliance monitoring and corrective action follow-up, performance measure validation and HEDIS audits, validation of performance improvement projects, child CAHPS survey, provider survey, consumer guide development, and technical assistance to the MQD and health plans.

- Promoting transparency and empowering member involvement in selecting a health plan by publicly posting health plan evaluations, EQRO results, consumer guides for members, and other reports on the MQD Web site.

- Using monitoring results and data to analyze and trend performance of the QUEST health plans and provide monetary incentives for performance that meets or exceeds goals, as measured by select HEDIS and CAHPS performance measures. The CY 2010 HEDIS results (validated in 2011) will be used for these incentives for the QUEST plans, and will serve as baseline data for future incentives for the QExA plans.

- Promoting strategies for non-duplication of quality monitoring by allowing health plans to be "deemed" compliant in select areas or standards where national accrediting bodies have found the health plan fully compliant. In 2011, Kaiser QUEST became the first plan to be deemed compliant in the area of credentialing for purposes of the EQRO compliance review. The State has also selected practice guidelines as an area for future deeming of compliance.

3. Plan-Specific Results, Conclusions, and Recommendations

Introduction

This section of the report describes the results of HSAG's 2011 EQR activities, and conclusions as to the quality and timeliness of, and access to, care furnished by the three QUEST health plans and two QExA health plans. Additionally, recommendations are offered to each plan to facilitate continued quality improvement in the Medicaid program.

The Appendix section of this report contains detailed information about the methodologies used to conduct the 2011 EQR activities. It also includes the objectives, technical methods of data collection and analysis, descriptions of data obtained, and descriptions of scoring terms and methods. In addition, a complete, detailed description of each activity conducted and the results obtained appear in the individual activity reports prepared by HSAG for each health plan and the MQD.

Compliance Monitoring Review

The 2011 compliance monitoring review activity focused on the federal managed care regulations and associated MQD contract requirements related to the structure and operations standards (42 CFR 438.214-230 and associated cross-references). The five standards used for the compliance assessment of the health plans provided information about the health plans' processes and performance in selecting and overseeing service providers and delegates; communicating key rights and requirements to members and providers through handbooks, manuals, correspondence, and provider contracts; and administering the grievance system, which included the health plans' processing of member grievances and appeals.

AlohaCare

Results

The scores from HSAG's 2011 compliance review of AlohaCare are displayed in Table 3-1 for the five areas reviewed:

Table 3-1––Compliance Standards and AlohaCare's Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	# *Not Scored*	Total Compliance Score
I	Delegation	11	11	6	5	0	0	0	77%
II	Member Information	33	32	28	4	0	1	0	94%
III	Grievance System	29	27	14	11	2	0	2	72%
IV	Provider Selection	9	9	9	0	0	0	0	100%
V	Credentialing	47	46	43	2	1	1	0	96%
	Totals	129	125	100	22	3	2	2	89%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The overall percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met,* then dividing this total by the total number of applicable elements.

Conclusions and Recommendations

AlohaCare's overall performance across all standards was 89 percent compliance, with strong performance noted in the areas of member information (94 percent), provider selection (100 percent), and credentialing (96 percent).

The health plan was found to have strong practices in place to select and contract with its provider network and to credential and recredential its providers. AlohaCare also demonstrated compliance in providing Medicaid enrollees with the required member information and for meeting language and format requirements in communications with its members. While these were three strong areas

of performance, AlohaCare received some recommendations for member information and credentialing and was required to:

- Improve the understandability of written letters to members (at or below a 6.9 grade reading level).
- Expand and clarify certain member handbook information.
- Perform timelier monitoring of federal and State sanctions and exclusions when credentialing providers.
- Ensure that any State or CMS survey it accepts in lieu of its own site visit meets the health plan's own organizational provider standards.
- Revise its credentialing policies/procedures to include a process for ensuring nonaccredited organizational providers credential their practitioners.

Two of the compliance review standards, related to delegation and the grievance system, scored considerably lower and provided the most opportunities for performance improvement. As a result of deficiencies identified in the area of delegation (which scored 77 percent), AlohaCare was required to:

- Include in its delegation agreements the specific duties being delegated, the delegate's reporting requirements, and all required contract provisions.
- Implement a delegation documentation tracking and archiving mechanism, and ensure assignment of responsibility for delegates.
- Ensure that all delegates are subject to an annual formal review by the health plan.

For the grievance system standard, with the lowest score of the five areas (72 percent), AlohaCare had required corrective actions to:

- Consider the earliest date possible as the filing date for grievances and appeals and to accept oral appeals, with follow-up to obtain a member's written appeal request.
- Issue member grievance resolution letters that address all grievance issues raised.
- Revise policies and other applicable documents, including member communications, to include more complete information about the option to continue benefits during an appeal or administrative hearing and the circumstances to which this may apply.
- Clarify and differentiate the processes for member appeals and provider grievances.

HMSA

Results

The scores from HSAG's 2011 compliance review of HMSA are displayed in Table 3-2 for the five areas reviewed:

Table 3-2––Compliance Standards and HMSA's Scores									
Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	# *Not Scored*	Total Compliance Score
I	Delegation	11	11	11	0	0	0	0	100%
II	Member Information	33	32	27	5	0	1	0	92%
III	Grievance System	29	27	15	11	1	0	2	76%
IV	Provider Selection	9	7	7	0	0	2	0	100%
V	Credentialing	47	46	44	2	0	1	0	98%
	Totals	129	123	104	18	1	4	2	92%
	Total # of Elements: The total number of elements in each standard.								
	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*								
	Total Compliance Score: The overall percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met,* then dividing this total by the total number of applicable elements.								

Conclusions and Recommendations

HMSA's overall performance across all standards was 92 percent compliance, with strong performance noted in the areas of delegation (100 percent), member information (92 percent), provider selection (100 percent), and credentialing (98 percent).

The health plan was found to have strong practices in place to select and oversee its delegates, and to select, contract with, and credential its provider network. HMSA also demonstrated compliance in providing its Medicaid enrollees with required member information and for meeting most of the requirements in communications with its members. While these were four strong areas of performance, HMSA received some recommendations related to member information and credentialing and was required to:

- Ensure member correspondence is understandable and written at a 6.9 or lower grade level.
- Revise and correct information in the member handbook related to grievances and appeals.
- Ensure that any State or CMS survey it accepts in lieu of its own site visit meets the health plan's own organizational provider standards.
- Revise its credentialing policies/procedures to include a process for ensuring nonaccredited organizational providers credential their practitioners.

The grievance system standard score was considerably lower (76 percent) and provided the most opportunities for performance improvement. As a result of deficiencies identified in this area, HMSA was required to:

- Ensure that grievance and appeal acknowledgment letters are sent to members within the required time frames.
- Revise its policy and process to ensure grievances are resolved and a resolution letter is sent within 30 days.
- Ensure that members are aware that grievance resolution letters can be made available in the member's primary language.

- Revise its policy and process to clarify that appeals may be accepted when filed orally and followed with a written request, and to consider the oral contact date as the date of filing.
- Clarify and differentiate the processes for member appeals and provider appeals, and ensure that members are included as parties to the appeal for those related to coverage, provision, or payment of medically necessary services.
- Ensure that appeals are resolved and that a resolution letter is sent within the required time frames.
- Establish processes to notify members of the reason for any time frame extension of an appeal resolution not requested by the member, and to notify the MQD related to expedited appeals as required in the contract.

Kaiser

Results

The scores from HSAG's 2011 compliance review of Kaiser are displayed in Table 3-3 for the five areas reviewed:

Table 3-3––Compliance Standards and Kaiser's Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	# *Not Scored*	Total Compliance Score
I	Delegation	11	0	0	0	0	11	0	NA
II	Member Information	33	32	29	3	0	1	0	95%
III	Grievance System	29	29	13	10	6	0	0	62%
IV	Provider Selection	9	8	8	0	0	1	0	100%
V	Credentialing	47	47	47	0	0	0	0	100%
	Totals	129	116	97	13	6	13	0	89%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The overall percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met,* then dividing this total by the total number of applicable elements.

Conclusions and Recommendations

Kaiser's overall performance across all standards was 89 percent compliance, with strong performance noted in the areas of member information (95 percent), provider selection (100 percent), and credentialing (100 percent). The health plan did not delegate any managed care functions; therefore, the delegation standard was not applicable. For the credentialing standard, Kaiser was deemed compliant because of its full accreditation by NCQA, as allowed by the State's quality strategy.

The health plan was found to have strong practices in place to select, contract with, and credential its provider network. Kaiser also demonstrated compliance in providing Medicaid enrollees with

most of the required member information and for meeting format requirements in communications with its members. While these were three strong areas of performance, Kaiser did receive some recommendations regarding its member information and was required to:

- Ensure member grievance and appeal resolution notices are understandable and at a 6.9 grade reading level or lower.
- Ensure all member materials include a language block informing the member how to access translation services or how to request the information in an alternate language.
- Revise and correct information in the member handbook related to grievances and appeals.

The grievance system standard score was considerably lower (62 percent), and provided the most opportunities for performance improvement. As a result of deficiencies identified in this area, Kaiser was required to:

- Develop policies and procedures to describe its inquiry process.
- Ensure that processes followed for Medicaid member grievances are consistent with policy requirements and the health plan's contract with the MQD.
- Treat all expressions of dissatisfaction as grievances and issue a written resolution even when the issue is resolved at the initial point of contact.

Evercare

Results

The scores from HSAG's 2011 compliance review of Evercare are displayed in Table 3-4 for the five areas reviewed:

Table 3-4––Compliance Standards and Evercare's Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	# *Not Scored*	Total Compliance Score
I	Delegation	11	11	9	2	0	0	0	91%
II	Member Information	33	32	26	6	0	1	0	91%
III	Grievance System	29	29	17	12	0	0	0	79%
IV	Provider Selection	9	7	7	0	0	2	0	100%
V	Credentialing	47	46	8	7	31	1	0	25%
	Totals	**129**	**125**	**67**	**27**	**31**	**4**	**0**	**64%**
	Total # of Elements: The total number of elements in each standard.								
	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*								
	Total Compliance Score: The overall percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.								

Conclusions and Recommendations

Evercare's overall performance across all standards was 64 percent compliance, with strong performance noted in the areas of delegation (91 percent), member information (91 percent), and provider selection (100 percent).

The health plan was found to have strong practices in place to select and contract with its provider network. Evercare also demonstrated its compliance in providing Medicaid enrollees with the required member information and for meeting language and format requirements in communications with its members. For the delegation standard, Evercare had an emerging structure and adequate practices in place to oversee its delegated managed care functions. While these were three strong areas of performance, Evercare did receive some recommendations related to delegation and member information, and was required to:

- Amend certain delegation agreements to contain all of the required contract provisions.
- Ensure member information materials and appeal resolution notices are understandable and at a 6.9 grade reading level or lower.
- Expand and clarify certain member handbook information (related to referrals, specialty services, authorization procedures, member liability for payment, and provider's ability to file grievances and appeals on behalf of the member).

Two of the compliance review standards, related to the grievance system (79 percent) and to credentialing (25 percent), scored considerably lower and provided the most opportunities for performance improvement. As a result of deficiencies identified in the area of grievance system, Evercare was required to:

- Ensure the timely processing of all appeal cases, including resolution and written acknowledgement.
- Ensure members are offered or made aware of available assistance with filing grievances and appeals and ensure staff members are trained on the member's right to file appeals orally or in writing.
- Clarify the definition of appeal in the policy, and ensure the appropriate process is followed for member grievances and appeals.
- Document and ensure that grievance and appeal decisions are made by qualified personnel who have not been previously involved in a decision on the case.
- Ensure appeal resolution letters contain all required member information.
- Provide prompt oral notice to members when a request for an expedited appeal is denied.
- Ensure that staff members are trained and follow correct processes regarding the member's right to have benefits continued during an appeal, when applicable.
- Clarify grievance system information given to providers, and ensure that member expressions of dissatisfaction are processed and tracked as grievances.

For the credentialing standard, Evercare's low score largely reflects the lack of well-defined health plan-specific policies and procedures as required by the numerous applicable NCQA standards. While Evercare's delegates for credentialing had policies and a process in place for credentialing

and recredentialing providers, the delegates' policies and processes did not appear to be driven by the health plan's own standards and criteria, but by that of the delegates. As a result, there were numerous deficiencies identified in the area of credentialing, and Evercare was required to:

- Develop and implement a well-defined process with written policies and procedures that articulate its decisions for applying the NCQA standards to its credentialing and recredentialing program.
- Ensure that one of its credentialing delegates produces accurate data for tracking recredentialing due dates.
- Develop and implement a mechanism for assessment of organizational providers and ensure that if a State or CMS survey is accepted in lieu of its own site visit, that the survey meets the health plan's own organizational provider standards.
- Revise one of its credentialing delegation agreements to include all of the provisions required by the NCQA standards.
- Ensure that future file reviews performed to oversee the delegated credentialing activities are performed on both credentialing delegates and include Hawaii credentialed providers.

Ohana

Results

The scores from HSAG's 2011 compliance review of Ohana are displayed in Table 3-5 for the five areas reviewed:

Table 3-5––Compliance Standards and Ohana's Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	# *Not Scored*	Total Compliance Score
I	Delegation	11	11	11	0	0	0	0	100%
II	Member Information	33	32	31	1	0	1	0	98%
III	Grievance System	29	29	26	3	0	0	0	95%
IV	Provider Selection	9	9	9	0	0	0	0	100%
V	Credentialing	47	46	40	6	0	1	0	93%
	Totals	129	127	117	10	0	2	0	96%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The overall percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met,* then dividing this total by the total number of applicable elements.

Conclusions and Recommendations

Ohana's overall performance across all standards was 96 percent compliance, with strong performance noted in all of the standards reviewed: delegation (100 percent), member information

(98 percent), grievance system (95 percent), provider selection (100 percent), and credentialing (93 percent).

The health plan was found to have compliant practices in place to select and oversee its delegated managed care functions, and to select, contract with, and credential its provider network. Ohana also demonstrated compliance in providing Medicaid enrollees with the required member information and for meeting language and format requirements in communications with its members. While these were five strong areas of performance, Ohana did receive some recommendations related to member information, grievance system, and credentialing, and was required to:

- Clarify and expand its member handbook information related to continuation of benefits during an appeal or administrative hearing, and regarding the rules that apply to a State administrative hearing.
- Revise applicable documents to provide a consistent and accurate definition of appeal and a consistent and accurate time frame for processing appeals.
- Clarify, correct, and expand grievance system information given to providers.
- Ensure accurate tracking and reporting of credentialing and recredentialing due dates.
- Revise the credentialing policies and procedures to address or clarify certain policy provisions required by the NCQA standards.
- Revise its forms and tools as needed to accurately list criteria to be evaluated for certain provider types.
- Develop and implement a mechanism for assessment of organizational providers and ensure that if a State or CMS survey is accepted in lieu of its own site visit, that the survey meets the health plan's own organizational provider standards.
- Revise the agreement with its credentialing delegate to accurately reflect the scope of the delegated activities.

An additional finding during the on-site review, which was outside the scope of the standards but required correction, prompted the following recommendation for Ohana:

- Develop a process to better manage pharmacy requests for additional information during the service authorization process, such as using the allowable authorization time frame or extending the time frame as necessary to make a service authorization determination.

Validation of Performance Measures—HEDIS Compliance Audits

Following are the results of the HEDIS compliance audits. Also presented in this section are the actual performance measure rates attained by each QUEST and QExA health plan on the six performance measures validated by HSAG, with comparisons to the HEDIS 2010 Medicaid percentiles and to the previous year's rates, where applicable. The performance measure rates validated by HSAG represented calendar year (CY) 2010 data. (Note: Values may be rounded in graphical presentation.)

The tables show the health plans' current year's performance for each HEDIS measure compared to the prior year's rate, the MQD Quality Strategy target, and the NCQA national Medicaid percentiles for evaluation of HEDIS measure rates. The performance level column illustrated in the tables rates the health plans' performance as follows:

★ = Below the national Medicaid 25th percentile
★★ = From the 25th percentile to the 49th percentile
★★★ = From the 50th percentile to the 74th percentile
★★★★ = From the 75th percentile to the 89th percentile
★★★★★ = At or above the 90th percentile

The MQD Quality Strategy targets represent the national HEDIS Medicaid 75th percentile for all measures except *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0)* and *Ambulatory Care—ED Visits* where lower rates indicate better performance. For these two measures the MQD Quality Strategy target is at or below the national HEDIS Medicaid 25th percentile.

Statistical significance testing was performed between the HEDIS 2010 and HEDIS 2011 rates to determine if the changes in rates from one year to the next were significant. These results are presented in the column, "Percentage Point Change." The percentage point change is presented as a + or -. Statistically significant improvement is represented in **green** and statistically significant declines are represented in **red**.

Of special note, when calculating their HEDIS performance measure rates, the QExA health plans, Evercare and Ohana, excluded enrollees who were dually eligible (i.e., enrollees with both Medicaid and Medicare coverage) when the Medicare coverage was through fee-for-service Medicare or an unknown/other Medicare plan. Because these data on Medicare services and encounters would not be readily available to the plans, eliminating this dually-eligible population from the measure calculations reduced the chance of negatively impacting the performance measure results. However, members dually enrolled in a plan's Medicaid program and Medicare plan were expected to be included in the rate calculations, which was consistent with the HEDIS specifications.

The following is a list of the HEDIS measures included in this report along with their abbreviations.

HEDIS Measure Name	Abbreviation
Childhood Immunization Status	CIS
Breast Cancer Screening	BCS
Chlamydia Screening in Women	CHL
Comprehensive Diabetes Care	CDC
Cholesterol Management for People with Cardiovascular Conditions	CMC
Ambulatory Care	AMB

AlohaCare

HEDIS Compliance Audit

The review team validated AlohaCare's IS capabilities for accurate HEDIS reporting. AlohaCare was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-6). This demonstrated that AlohaCare had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by AlohaCare were prepared according to the 2011 HEDIS specifications.

Because AlohaCare was found to be *Fully Compliant* with HEDIS reporting requirements, HSAG provided no recommendations for performance measure reporting. Note: The call center standards were not applicable to the measures HSAG validated.

Table 3-6––AlohaCare: HEDIS Compliance Audit Measure Results

Information System						
IS 1.0 – Medical Data	**IS 2.0 – Enrollment Data**	**IS 3.0 – Provider Data**	**IS 4.0 – Medical Record Data**	**IS 5.0 – Supplemental Data**	**IS 6.0 – Call Center**	**IS 7.0 – Data Integration**
Fully Compliant	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

AlohaCare's audit results were consistent with the NCQA category of *Report (R)* for its selected measures.

Table 3-7––AlohaCare: HEDIS Compliance Audit Measure Results

Selected Measures					
CIS	**BCS**	**CHL**	**CDC**	**CMC**	**AMB**
Report	***Report***	***Report***	***Report***	***Report***	***Report***

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE HEALTH MEASURES

Overall AlohaCare showed improvement in rates for all *CIS* antigens except *HiB*. While AlohaCare showed some improvement, performance was below the national HEDIS 2010 Medicaid 25th percentile and the MQD Quality Strategy targets. Statistically significant improvement was seen in the *DTaP* and *IPV* antigen rates. AlohaCare's performance in the Children's Preventive Health measures represents opportunities for improvement. While this measure is reported as a hybrid measure, including both administrative and medical record data, AlohaCare should investigate ways to obtain more complete immunization data from its providers and/or from supplemental databases.

Table 3-8––AlohaCare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Childhood Immunization Status					
DTaP	60.1%	68.9%	**+8.8**	85.2%	★
IPV	73.0%	81.8%	**+8.8**	93.7%	★
MMR	83.5%	83.9%	+0.4	93.9%	★
HiB	83.9%	79.6%	-4.3	96.6%	★
Hepatitis B	72.0%	73.7%	+1.7	94.3%	★
VZV	82.5%	83.9%	+1.4	93.9%	★
Pneumococcal Conjugate	61.3%	66.7%	+5.4	84.0%	★
Combination #2	53.5%	58.6%	+5.1	81.6%	★
Combination #3	50.9%	55.5%	+4.6	76.6%	★

WOMEN'S HEALTH MEASURES

AlohaCare's performance in the *Breast Cancer Screening* measure showed a 2.0 percentage point increase but fell below the national HEDIS Medicaid 25th percentile. AlohaCare's performance for the three *Chlamydia Screening* indicators remained fairly stable but ranked below the national HEDIS Medicaid 50th percentile. None of the rates met the MQD Quality Strategy targets. Both of these measures rely on complete administrative claims and encounter data. AlohaCare needs to work with its providers to ensure that data are being submitted in a timely manner. AlohaCare should also determine if all lab data are being received, particularly for the *CHL* measure.

Table 3-9––AlohaCare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Breast Cancer Screening					
Total	38.6%	40.6%	+ 2.0	59.6%	★
Chlamydia Screening in Women					
16–20 Years	52.4%	51.5%	- 0.9	61.1%	★
21–24 Years	58.3%	58.7%	+ 0.4	69.1%	★★
Total	55.3%	55.0%	- 0.3	63.7%	★★

CARE FOR CHRONIC CONDITIONS

AlohaCare's rate for the *CMC—Screening* indicator increased by 1.2 percentage points: however, the *CMC—Control* rate dropped by 8.3 percentage points. The drop in the *Control* rate could indicate incomplete laboratory results data. AlohaCare should ensure that all lab data are being received. AlohaCare had statistically significant declines in performance for two of the *CDC* measures, *HbA1c Poor Control* and *Blood Pressure Control (<140/90). HbA1c Poor Control* increased by 10.6 percentage points and benchmarked above the national HEDIS 2010 Medicaid 90th percentile in performance. However, a lower rate and percentile ranking indicate better performance for this *CDC* measure. *Blood Pressure Control (140/90)* dropped by 6.7 percentage points and ranked below the national HEDIS 2010 Medicaid 10th percentile. All but one rate ranked below the national HEDIS 2010 Medicaid 25th percentile (including *HbA1c Poor Control* since it is an inverse measure), representing many opportunities for improvement. AlohaCare did not meet the MQD Quality Strategy target for any of the care for chronic conditions measures.

Table 3-10––AlohaCare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Cholesterol Management for Patients with Cardiovascular Conditions					
LDL-C Screening	72.5%	73.7%	+ 1.2	84.8%	★
LDL-C Control	42.5%	34.2%	- 8.3	50.0%	★
Comprehensive Diabetes Care					
HbA1c Testing	77.0%	74.3%	- 2.7	86.4%	★
HbA1c Poor Control (>9.0%)[€]	57.1%	67.7%	**+ 10.6**	33.8%	★★★★★
HbA1c Control (<8.0%)	26.8%	26.6%	- 0.2	54.2%	★
HbA1c Control (<7.0%)	15.5%	17.0%	+ 1.5	39.5%	★
Eye Exam	45.4%	42.0%	- 3.4	63.7%	★★
LDL-C Screening	66.6%	66.4%	- 0.2	80.1%	★
LDL-C Control	20.8%	22.8%	+ 2.0	40.9%	★
Nephropathy	71.9%	69.7%	- 2.2	82.7%	★
Blood Pressure Control (<140/80)[±]		27.4%			
Blood Pressure Control (<140/90)	52.9%	46.2%	**- 6.7**	68.2%	★

[€] A lower rate (fewer stars) indicates better performance for this measure. The MQD Quality Strategy target is the national HEDIS 2010 Medicaid 25th percentile.

[±] Specifications for this indicator changed from <130/80 to <140/80; therefore, no benchmark or comparison data are available.

UTILIZATION MEASURES

AlohaCare demonstrated a decline in *ED Visits* from HEDIS 2010 to HEDIS 2011. AlohaCare's rate was below the MQD Quality Strategy target of 58.5, which represents the national HEDIS 2010 Medicaid 25th percentile. For this indicator, a lower rate generally indicates better performance. HEDIS 2011 was the first year that HSAG validated the *Outpatient Visits* measure. AlohaCare reported a rate of 264.6 outpatient visits per 1,000 member months, which was below the MQD Quality Strategy target of 416.7. AlohaCare performed below the national HEDIS 2010 Medicaid 25th percentile for this measure and should investigate the reason for the low rate of outpatient visits among its members. While the HEDIS percentiles are provided for reference, it is important to assess utilization based on the characteristics of the plan's population and service delivery model.

Table 3-11––AlohaCare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Quality Strategy Target	Performance Level
Ambulatory Care				
ED Visits/1,000	48.8	41.6	58.5	★
Outpatient Visits/1,000		264.6	416.7	★

CONCLUSIONS AND RECOMMENDATIONS

AlohaCare was the lowest performing QUEST health plan, with the majority of its rates benchmarking below the national HEDIS 2010 Medicaid 25th percentile. AlohaCare should ensure that claims and encounter data are complete and accurate, and that opportunities for use of supplemental data sources are explored. Data volume trending reports should be produced monthly and report cards should be given to providers. Providers should be educated on the importance of submitting encounter data, and AlohaCare should consider sanctions for non-compliant providers. AlohaCare should also review the completeness of its laboratory data. Many of the *CDC* measures rely on laboratory results data; without these data, a health plan must rely on medical record data to increase its rate.

AlohaCare should offer member education specific to disease conditions and on overall health and wellness. For a subset of members, more active care/disease management programs may be indicated. AlohaCare should also investigate reasons for low outpatient visit rates among its members. This low visit rate could be related to AlohaCare's low performance on many of its HEDIS rates.

HMSA

HEDIS Compliance Audit

The review team validated HMSA's IS capabilities for accurate HEDIS reporting. HMSA was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-12). This demonstrated that HMSA had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by HMSA were prepared according to the 2011 HEDIS specifications.

Because HMSA was found to be *Fully Compliant* with HEDIS reporting requirements, HSAG provided no recommendations for performance measure reporting. Note: The call center standards were not applicable to the measures HSAG validated.

Table 3-12––HMSA: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	**IS 2.0 – Enrollment Data**	**IS 3.0 – Provider Data**	**IS 4.0 – Medical Record Data**	**IS 5.0 – Supplemental Data**	**IS 6.0 – Call Center**	**IS 7.0 – Data Integration**
Fully Compliant	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

HMSA's audit results were consistent with the NCQA category of *Report (R)* for its selected measures.

Table 3-13––HMSA: HEDIS Compliance Audit Measure Results					
Selected Measures					
CIS	**BCS**	**CHL**	**CDC**	**CMC**	**AMB**
Report	***Report***	***Report***	***Report***	***Report***	***Report***

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

HMSA showed statistically significant improvement in three of the *CIS* indicators, including *Combination #3*. HMSA's *Pneumococcal Conjugate* improved by 13.1 percentage points and benchmarked above the national HEDIS 2010 Medicaid 50th percentile. One indicator, *HiB*, showed a statistically significant decline of 4.8 percentage points and benchmarked below the national HEDIS 2010 Medicaid 25th percentile. HMSA also performed below the 25th percentile for the *IPV*, *MMR*, and *VZV* antigens. HMSA did not meet the MQD Quality Strategy targets for any of the *CIS* indicators. Low performance across all indicators for the *CIS* measure represents an opportunity of improvement. HMSA should ensure that providers are submitting claims and encounter data for all administered vaccines.

Table 3-14––HMSA's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Childhood Immunization Status					
DTaP	70.1%	78.4%	**+ 8.2**	85.2%	★★
IPV	81.5%	85.6%	+ 4.1	93.7%	★
MMR	90.5%	87.4%	- 3.2	93.9%	★
HiB	91.2%	86.4%	**- 4.8**	96.6%	★
Hepatitis B	88.3%	90.8%	+ 2.5	94.3%	★★
VZV	87.8%	84.9%	- 2.9	93.9%	★
Pneumococcal Conjugate	66.9%	80.1%	**+ 13.1**	84.0%	★★★
Combination #2	67.2%	70.6%	+ 3.4	81.6%	★★
Combination #3	57.9%	67.9%	**+ 10.0**	76.6%	★★

WOMEN'S HEALTH MEASURES

HMSA performed from the 50th to the 74th percentile for all of the women's health measures. While all of the rates improved from HEDIS 2010, HMSA did not meet the MQD Quality Strategy targets. HMSA demonstrated statistically significant improvement in all three *CHL* rates, ranging from an increase of 7.0 percentage points to an increase of 13.0 percentage points. HMSA should identify the successful strategies it employed to increase these rates and continue its improvement efforts for these measures.

Table 3-15––HMSA's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Breast Cancer Screening					
Total	52.9%	53.8%	+ 0.9	59.6%	★★★
Chlamydia Screening in Women					
16–20 Years	50.7%	57.7%	**+ 7.0**	61.1%	★★★
21–24 Years	53.4%	66.4%	**+ 13.0**	69.1%	★★★
Total	52.0%	62.0%	**+ 10.0**	63.7%	★★★

CARE FOR CHRONIC CONDITIONS

HMSA's *CMC-Screening* rate improved by 0.9 percentage point; however, its *CMC-Control* rate dropped significantly by 14.6 percentage points. Both rates benchmarked below the national HEDIS 2010 Medicaid 25th percentile representing an area for improvement for HMSA. HMSA improved performance in two of the ten *CDC* indicators, *Eye Exam* and *LDL-C Control*. All of the other indicator rates remained the same or declined. Performance ranged from above the 50th percentile to below the 25th percentile. HMSA did not meet the MQD Quality Strategy target for any of the *CDC* measures. HMSA should ensure that all claims and encounter data are received and processed in a timely manner. Since many of these indicators rely on laboratory results, HMSA should review the completeness of laboratory data.

Table 3-16––HMSA's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Cholesterol Management for Patients with Cardiovascular Conditions					
LDL-C Screening	76.5%	77.4%	+ 0.9	84.8%	★
LDL-C Control	45.1%	30.5%	**- 14.6**	50.0%	★
Comprehensive Diabetes Care					
HbA1c Testing	78.1%	76.4%	- 1.7	86.4%	★★
HbA1c Poor Control (>9.0%)[€]	50.6%	53.3%	+ 2.8	33.8%	★★★
HbA1c Control (<8.0%)	39.4%	38.9%	- 0.5	54.2%	★★
HbA1c Control (<7.0%)	24.7%	24.7%	0.0	39.5%	★
Eye Exam	45.8%	51.6%	+ 5.8	63.7%	★★
LDL-C Screening	78.8%	76.6%	- 2.2	80.1%	★★★
LDL-C Control	33.9%	36.3%	+ 2.4	40.9%	★★★
Nephropathy	72.1%	70.8%	- 1.3	82.7%	★
Blood Pressure Control (<140/80)[±]		37.0%			
Blood Pressure Control (<140/90)	58.0%	56.2%	- 1.8	68.2%	★★

[€] A lower rate (fewer stars) indicates better performance for this measure. The MQD Quality Strategy target is the national HEDIS 2010 Medicaid 25th percentile.

[±] Specifications for this indicator changed from <130/80 to <140/80; therefore, no benchmark or comparison data are available.

UTILIZATION MEASURES

HMSA's *ED Visits* rates remained fairly stable from HEDIS 2010 to HEDIS 2011. HMSA was below the MQD Quality Strategy target of 58.5, which represents the national HEDIS 2010 Medicaid 25th percentile. For this indicator, a lower rate generally indicates better performance. HEDIS 2011 was the first year that HSAG validated the *Outpatient Visits* measure. HMSA reported a rate of 350.8 outpatient visits per 1,000 member months, which was below the MQD Quality Strategy target of 416.7. HMSA performed below the national HEDIS 2010 Medicaid 50th percentile for this measure and should investigate the reason for lower outpatient visits among its members. While the HEDIS percentiles are provided for reference, it is important to assess utilization based on the characteristics of the plan's population and service delivery model.

Table 3-17––HMSA's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Quality Strategy Target	Performance Level
Ambulatory Care				
ED Visits/1,000	39.6	39.2	58.5	★
Outpatient Visits/1,000		350.8	416.7	★★

Conclusions and Recommendations

HMSA demonstrated average to below-average performance across most of the HEDIS 2011 measures. While several of the CIS indicators showed statistically significant improvement, overall performance was below the national HEDIS 2010 Medicaid 50th percentile. HMSA should investigate the reason for low CIS rates, to determine, for example, whether it is a data completeness or member compliance issue. Performance for the women's care measures was slightly above average but still represented an area for improvement. HMSA has room to improve across all care for chronic conditions measures. HMSA should monitor claims and encounter data completeness and work to ensure laboratory data are received. Many of the CDC indicators rely on laboratory results; without these data, medical record review is necessary. Data volume trending should be monitored monthly and providers should be notified of their performance.

HMSA should continue to offer member education specific to disease conditions and on overall health and wellness. Health education programs for a variety of diabetes-related issues, including healthy eating and weight loss programs have shown to be effective in managing diabetes-related complications. Both written and electronic health education materials have also been shown to be useful as long as the patient can understand them. For a subset of members, more active care/disease management programs may be indicated.

Kaiser

HEDIS Compliance Audit

The review team validated Kaiser's IS capabilities for accurate HEDIS reporting. Kaiser was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-18). This demonstrated that Kaiser had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by Kaiser were prepared according to the 2011 HEDIS specifications.

Because Kaiser was found to be *Fully Compliant* with HEDIS reporting requirements, HSAG provided no recommendations for performance measure reporting. Note: The call center standards were not applicable to the measures HSAG validated.

Table 3-18––Kaiser: HEDIS Compliance Audit Measure Results

Information System						
IS 1.0 – Medical Data	**IS 2.0 – Enrollment Data**	**IS 3.0 – Provider Data**	**IS 4.0 – Medical Record Data**	**IS 5.0 – Supplemental Data**	**IS 6.0 – Call Center**	**IS 7.0 – Data Integration**
Fully Compliant	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

Kaiser's audit results were consistent with the NCQA category of *Report (R)* for five of the six selected measures. One measure, *CMC*, was reported as *Not Applicable (NA)* because of a small eligible population (denominator <30) for the measure.

Table 3-19––Kaiser: HEDIS Compliance Audit Measure Results

Selected Measures					
CIS	**BCS**	**CHL**	**CDC**	**CMC**	**AMB**
Report	***Report***	***Report***	***Report***	***Not Applicable***	***Report***

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

For the *CIS* measure, Kaiser exceeded the national HEDIS 2010 Medicaid 90th percentile in five of the nine indicators. Although they were not statistically significant improvements over last year, Kaiser did show increases in seven of the nine indicators as compared to the HEDIS 2010 rates. Kaiser performed lowest on the *HiB* indicator, benchmarking below the 50th percentile. Kaiser exceeded the MQD Quality Strategy targets for all antigens except *MMR*, *HiB*, and *VZV*.

Table 3-20––Kaiser's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Childhood Immunization Status					
DTaP	89.8%	91.1%	+ 1.3	85.2%	★★★★★
IPV	94.9%	95.3%	+ 0.4	93.7%	★★★★★
MMR	93.9%	93.5%	- 0.4	93.9%	★★★
HiB	95.9%	95.0%	- 0.9	96.6%	★★
Hepatitis B	95.1%	95.3%	+ 0.2	94.3%	★★★★
VZV	93.4%	93.5%	+ 0.1	93.9%	★★★
Pneumococcal Conjugate	88.8%	90.6%	+ 1.8	84.0%	★★★★★
Combination #2	88.6%	89.1%	+ 0.5	81.6%	★★★★★
Combination #3	86.6%	87.9%	+ 1.3	76.6%	★★★★★

WOMEN'S HEALTH MEASURES

Kaiser exceeded the MQD Quality Strategy targets for all women's health measures. Kaiser benchmarked above the national HEDIS 2010 Medicaid 90th percentile for the *BCS* measure and *CHL—16–20 Years* measure. While all of the *CHL* rates dropped by at least 5 percentage points, none of these decreases was statistically significant and performance was above the established targets. Kaiser may want to investigate the reasons for the drop in *CHL* rates in order to improve or maintain its high performance.

Table 3-21––Kaiser's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target*	Performance Level
Breast Cancer Screening					
Total	77.3%	78.4%	+ 1.1	59.6%	★★★★★
Chlamydia Screening in Women					
16–20 Years	72.6%	67.5%	- 5.1	61.1%	★★★★★
21–24 Years	76.6%	71.3%	- 5.4	69.1%	★★★★
Total	74.6%	69.3%	- 5.3	63.7%	★★★★

CARE FOR CHRONIC CONDITIONS

Kaiser did not have a large enough population to report a valid rate for either *CMC* measure. Kaiser had statistically significant improvement in six of the ten *CDC* indicators. Kaiser had the greatest improvement in the *HbA1c Poor Control* indicator (decline of 11.9 percentage points) where a lower rate indicates better performance. While the *HbA1c Control (<7.0%)* rate improved by 7.5 percentage points, it performed below the MQD Quality Strategy target and the national HEDIS 2010 Medicaid 25th percentile. Kaiser performed above the 90th percentile in all *CDC* indicators except the *HbA1c Control* indicators, representing an area for improvement. Kaiser should verify laboratory data completeness and educate its members on the importance of diabetes care and management.

Table 3-22––Kaiser's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Cholesterol Management for Patients with Cardiovascular Conditions					
LDL-C Screening	NA	NA	-	84.8%	-
LDL-C Control	NA	NA	-	50.0%	-
Comprehensive Diabetes Care					
HbA1c Testing	88.3%	92.8%	**+ 4.5**	86.4%	★★★★★
HbA1c Poor Control (>9.0%)[€]	51.7%	39.8%	**-11.9**	33.8%	★★
HbA1c Control (<8.0%)	36.0%	46.7%	**+ 10.7**	54.2%	★★★
HbA1c Control (<7.0%)	18.4%	25.9%	**+ 7.5**	39.5%	★
Eye Exam	76.0%	72.6%	- 3.4	63.7%	★★★★★
LDL-C Screening	85.2%	89.7%	**+ 4.5**	80.1%	★★★★★
LDL-C Control	42.5%	46.5%	+ 4.0	40.9%	★★★★★
Nephropathy	84.5%	90.7%	**+ 6.2**	82.7%	★★★★★
Blood Pressure Control (<140/80)[±]		62.7%			
Blood Pressure Control (<140/90)	76.6%	80.4%	+ 3.8	68.2%	★★★★★

[€] A lower rate (fewer stars) indicates better performance for this measure. The MQD Quality Strategy target is the national HEDIS 2010 Medicaid 25th percentile.

[±] Specifications for this indicator changed from <130/80 to <140/80; therefore, no benchmark or comparison data are available.

UTILIZATION MEASURES

Kaiser demonstrated a decline in *ED Visits* from HEDIS 2010 to HEDIS 2011. Kaiser's rate was well below the MQD Quality Strategy target of 58.5, which represents the national HEDIS 2010 Medicaid 25th percentile. For this indicator, a lower rate generally indicates better performance. HEDIS 2011 was the first year that HSAG validated the *Outpatient Visits* measure. Kaiser reported a rate of 306.7 outpatient visits per 1,000 member months, which was below the MQD Quality Strategy target of 416.7. Kaiser performed below the national HEDIS 2010 Medicaid 25th percentile for this measure and should investigate the reason for low outpatient visits among its members. While the HEDIS percentiles are provided for reference, it is important to assess utilization based on the characteristics of the plan's population and service delivery model.

Table 3-23––Kaiser's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Quality Strategy Target	Performance Level
Ambulatory Care				
ED Visits/1,000	28.6	22.3	58.5	★
Outpatient Visits/1,000		306.7	416.7	★

CONCLUSIONS AND RECOMMENDATIONS

Kaiser was the top-performing QUEST health plan across all measures for HEDIS 2011. Kaiser performed at or above the MQD Quality Strategy target for over half of the reported rates. While Kaiser's overall performance was high, areas for improvement still existed. Kaiser's *HbA1c Control* rates have room for improvement. Kaiser should ensure all laboratory data are complete and work to educate members on the importance of disease management. Health education programs for a variety of diabetes-related issues, including healthy eating and weight loss, have shown to be effective in managing diabetes-related complications. Both written and electronic health education materials have also been shown to be useful as long as the patient can understand them. For a subset of members, more active care/disease management programs may be indicated.

Evercare

HEDIS Compliance Audit

The review team validated Evercare's IS capabilities for accurate HEDIS reporting. Evercare was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-24). This demonstrated that Evercare had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by Evercare were prepared according to the 2011 HEDIS specifications.

Although Evercare was found to be *Fully Compliant* with HEDIS reporting requirements, HSAG provided a recommendation that Evercare also perform claims audits at the individual contract level to identify any claims processing issues. At the time of this audit, current claims processing and audits were performed at a corporate level in Minnesota. Note: The call center standards were not applicable to the measures HSAG validated.

Table 3-24––Evercare: HEDIS Compliance Audit Measure Results

Information System						
IS 1.0 – Medical Data	**IS 2.0 – Enrollment Data**	**IS 3.0 – Provider Data**	**IS 4.0 – Medical Record Data**	**IS 5.0 – Supplemental Data**	**IS 6.0 – Call Center**	**IS 7.0 – Data Integration**
Fully Compliant	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

Evercare's audit results were consistent with the NCQA category of *Report (R)* for five of the six selected measures. One measure, *CIS*, was reported as *Not Applicable (NA)* because of a small eligible population (denominator <30) for the measure.

Table 3-25––Evercare: HEDIS Compliance Audit Measure Results

Selected Measures					
CIS	**BCS**	**CHL**	**CDC**	**CMC**	**AMB**
Not Applicable	***Report***	***Report***	***Report***	***Report***	***Report***

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

Evercare did not have a large enough population to report valid rates for the *CIS* measure. All antigens were reported as *NA*. The QExA health plan population consists largely of dual eligible members and represents an older and sicker population compared to the QUEST health plans; as such, *CIS* may not be the most useful measure for the QExA plans to report.

Table 3-26––Evercare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Childhood Immunization Status					
DTaP	NA	NA	-	85.2%	-
IPV	NA	NA	-	93.7%	-
MMR	NA	NA	-	93.9%	-
HiB	NA	NA	-	96.6%	-
Hepatitis B	NA	NA	-	94.3%	-
VZV	NA	NA	-	93.9%	-
Pneumococcal Conjugate	NA	NA	-	84.0%	-
Combination #2	NA	NA	-	81.6%	-
Combination #3	NA	NA	-	76.6%	-

WOMEN'S HEALTH MEASURES

Evercare performed below the MQD Quality Strategy target for the *BCS* measure and benchmarked below the national HEDIS 2010 Medicaid 50th percentile. Evercare performed below the national HEDIS 2010 Medicaid 25th percentile for the *CHL* indicators with reportable rates. While performance was low for these measures, the eligible populations were small. The demographics of the QExA health plans should be considered when reviewing performance.

Table 3-27––Evercare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Breast Cancer Screening					
Total	NA	49.5%	-	59.6%	★★
Chlamydia Screening in Women					
16–20 Years	31.3%	NA	-	61.1%	-
21–24 Years	NA	33.3%	-	69.1%	★
Total	28.9%	26.4%	- 2.4	63.7%	★

CARE FOR CHRONIC CONDITIONS

Evercare performed below the MQD Quality Strategy targets for both *CMC* measures for HEDIS 2011. Evercare showed statistically significant improvement in three of the four *CDC* indicators it had also reported for HEDIS 2010. The *LDL-C Screening* rate exceeded the MQD Quality Strategy target by 0.6 percentage point. Evercare demonstrated a statistically significant change in the *HbA1c Testing* rate, increasing by 11.5 percentage points; the *Eye Exam* rate increased by 18.0 percentage points. Overall performance for the Care for Chronic Conditions measures was below average and represents opportunities for improvement. Evercare should ensure all claims, encounter, and lab data are being received from its providers.

Table 3-28––Evercare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Cholesterol Management for Patients with Cardiovascular Conditions					
LDL-C Screening	NA	83.6%	-	84.8%	★★★
LDL-C Control	NA	42.5%	-	50.0%	★★
Comprehensive Diabetes Care					
HbA1c Testing	69.5%	80.9%	**+ 11.5**	86.4%	★★
HbA1c Poor Control (>9.0%)[€]	NR	50.9%	-	33.8%	★★★
HbA1c Control (<8.0%)	NR	41.7%	-	54.2%	★★
HbA1c Control (<7.0%)	NR	28.2%	-	39.5%	★★
Eye Exam	41.2%	59.2%	**+ 18.0**	63.7%	★★★
LDL-C Screening	65.1%	80.7%	**+ 15.6**	80.1%	★★★★
LDL-C Control	NR	40.1%	-	40.9%	★★★
Nephropathy	83.6%	81.6%	- 2.0	82.7%	★★★
Blood Pressure Control (<140/80)[±]		29.3%			
Blood Pressure Control (<140/90)	NR	38.9%	-	68.2%	★

[€] A lower rate (fewer stars) indicates better performance for this measure. The MQD Quality Strategy target is the national HEDIS 2010 Medicaid 25th percentile.

[±] Specifications for this indicator changed from <130/80 to <140/80; therefore, no benchmark or comparison data are available.

UTILIZATION MEASURES

Evercare's *ED Visits* rate increased from HEDIS 2010 to HEDIS 2011. Evercare's rate exceeded the MQD Quality Strategy target of 58.5, which represents the national HEDIS 2010 Medicaid 25th percentile. HEDIS 2011 was the first year that HSAG validated the *Outpatient Visits* measure. Evercare reported a rate of 798.9 outpatient visits per 1,000 member months, which exceeded the MQD Quality Strategy target of 416.7, and benchmarked above the national HEDIS 2010 Medicaid 90th percentile. While the HEDIS percentiles are provided for reference, it is important to assess utilization based on the characteristics of the plan's population and service delivery model.

Table 3-29––Evercare's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Quality Strategy Target	Performance Level
Ambulatory Care				
ED Visits/1,000	59.7	64.2	58.5	★★
Outpatient Visits/1,000		798.9	416.7	★★★★★

CONCLUSIONS AND RECOMMENDATIONS

Evercare's overall performance was average to below average. Evercare was unable to report valid rates for the *CIS* measures because there was not a large enough eligible population; therefore all rates were reported as *NA.* Areas for improvement existed for all women's care and chronic care measures. To improve performance on these measures, Evercare should monitor data completeness to ensure all data are being received from providers accurately and in a timely manner. Monthly volume trending reports should be monitored, and report cards could be given to all providers. Evercare should increase the volume of laboratory results data. Many of the *CDC* measures rely on results data; without complete laboratory data, medical record data are necessary to improve rates.

Member compliance with disease management recommendations and guidelines is also important. Education and outreach should be targeted at high-risk, noncompliant members, and more active care/disease management programs may be indicated for these members.

Evercare reported high *ED Visits* and *Outpatient Visits* rates. While it is recognized that the QExA health plans may enroll sicker individuals with more chronic conditions than the QUEST health plans, Evercare should review the top diagnoses for these visits and determine if additional disease management programs or other system interventions could be implemented to decrease any inappropriate use of the ED.

Ohana

HEDIS Compliance Audit

The review team validated Ohana's IS capabilities for accurate HEDIS reporting. Ohana was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-30). This demonstrated that Ohana had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by Ohana were prepared according to the 2011 HEDIS specifications.

Because Ohana was found to be *Fully Compliant* with HEDIS reporting requirements, HSAG provided no recommendations for performance measure reporting. Note: The call center standards were not applicable to the measures HSAG validated.

Table 3-30––Ohana: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	**IS 2.0 – Enrollment Data**	**IS 3.0 – Provider Data**	**IS 4.0 – Medical Record Data**	**IS 5.0 – Supplemental Data**	**IS 6.0 – Call Center**	**IS 7.0 – Data Integration**
Fully Compliant	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

Ohana's audit results were consistent with the NCQA category of Report (R) for its selected measures.

Table 3-31––Ohana: HEDIS Compliance Audit Measure Results					
Selected Measures					
CIS	**BCS**	**CHL**	**CDC**	**CMC**	**AMB**
Report	***Report***	***Report***	***Report***	***Report***	***Report***

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

Ohana performed well below the MQD Quality Strategy targets and the national HEDIS 2010 Medicaid 25th percentile for all HEDIS 2011 *CIS* rates. Ohana did not have a large enough population to report valid rates for the *CIS* measure in HEDIS 2010; all antigens were reported as *NA*, therefore, year-to-year comparisons were not possible. The QExA health plan members are largely dual eligibles and represent an older and sicker population compared to the QUEST health plans; as such, *CIS* may not be the most useful measure for the QExA plans to report.

Table 3-32––Ohana's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Childhood Immunization Status					
DTaP	NA	16.7%	-	85.2%	★
IPV	NA	20.8%	-	93.7%	★
MMR	NA	35.4%	-	93.9%	★
HiB	NA	20.8%	-	96.6%	★
Hepatitis B	NA	20.8%	-	94.3%	★
VZV	NA	37.5%	-	93.9%	★
Pneumococcal Conjugate	NA	16.7%	-	84.0%	★
Combination #2	NA	16.7%	-	81.6%	★
Combination #3	NA	14.6%	-	76.6%	★

WOMEN'S HEALTH MEASURES

Ohana performed below the MQD Quality Strategy target for the *BCS* measure and benchmarked below the national HEDIS 2010 Medicaid 25th percentile. While Ohana improved its *CHL* rates for two indicators from HEDIS 2010, performance was below the national HEDIS 2010 Medicaid 25th percentile for all three *CHL* indicators. While performance was low for these measures, the eligible populations were small. The demographics of the QExA health plans should be considered when reviewing performance.

Table 3-33––Ohana's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Breast Cancer Screening					
Total	NA	43.4%	-	59.6%	★
Chlamydia Screening in Women					
16–20 Years	26.4%	23.9%	- 2.5	61.1%	★
21–24 Years	35.7%	44.6%	+ 8.9	69.1%	★
Total	31.2%	33.3%	+ 2.1	63.7%	★

CARE FOR CHRONIC CONDITIONS

Ohana performed below the MQD Quality Strategy targets for both *CMC* measures for HEDIS 2011. Ohana showed statistically significant improvement in the *CDC—Eye Exam* indicator and benchmarked above the national HEDIS 2010 Medicaid 50th percentile. Ohana had statistically significant declines in four *CDC* indicators: *HbA1c Poor Control*, *LDL-C Control*, *Nephropathy*, and *Blood Pressure Control (<140/90)*. Overall performance for the Care for Chronic Conditions measures was below average and represents opportunities for improvement. Ohana should ensure all claims, encounter, and lab data are being received from its providers.

Table 3-34––Ohana's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Percentage Point Change	Quality Strategy Target	Performance Level
Cholesterol Management for Patients with Cardiovascular Conditions					
LDL-C Screening	NA	78.3%	-	84.8%	★★
LDL-C Control	NA	29.8%	-	50.0%	★★
Comprehensive Diabetes Care					
HbA1c Testing	83.2%	82.1%	- 1.1	86.4%	★★★
HbA1c Poor Control (>9.0%)[€]	52.4%	59.5%	**+ 7.1**	33.8%	★★★★
HbA1c Control (<8.0%)	40.2%	36.5%	- 3.6	54.2%	★
HbA1c Control (<7.0%)	32.4%	27.8%	- 4.6	39.5%	★
Eye Exam	43.4%	54.0%	**+ 10.6**	63.7%	★★★
LDL-C Screening	79.0%	74.8%	- 4.2	80.1%	★★
LDL-C Control	31.9%	25.6%	**- 6.4**	40.9%	★
Nephropathy	84.3%	79.7%	**- 4.6**	82.7%	★★★
Blood Pressure Control (<140/80)[±]		33.2%			
Blood Pressure Control (<140/90)	59.0%	51.1%	**- 7.8**	68.2%	★

[€] A lower rate (fewer stars) indicates better performance for this measure. The MQD Quality Strategy target is the national HEDIS 2010 Medicaid 25th percentile.

[±] Specifications for this indicator changed from <130/80 to <140/80; therefore, no benchmark or comparison data are available.

UTILIZATION MEASURES

Ohana's *ED Visits* rate increased from HEDIS 2010 to HEDIS 2011 and exceeded the MQD Quality Strategy target of 58.5, which represents the national HEDIS 2010 Medicaid 25th percentile. HEDIS 2011 was the first year that HSAG validated the *Outpatient Visits* measure. Ohana reported a rate of 628.3 outpatient visits per 1,000 member months, which exceeded the MQD Quality Strategy target of 416.7, and benchmarked above the national HEDIS 2010 Medicaid 90th percentile. While the HEDIS percentiles are provided for reference, it is important to assess utilization based on the characteristics of the plan's population and service delivery model.

Table 3-35––Ohana's HEDIS Results

	HEDIS 2010 Rate	HEDIS 2011 Rate	Quality Strategy Target	Performance Level
Ambulatory Care				
ED Visits/1,000	80.6	81.1	58.5	★★★★
Outpatient Visits/1,000		628.3	416.7	★★★★★

CONCLUSIONS AND RECOMMENDATIONS

Ohana's overall performance was average to below average. Areas for improvement existed for all children's preventive care, women's care, and chronic care measures. To improve performance on these measures Ohana should monitor data completeness to ensure all data are being received from providers accurately and in a timely manner. Monthly volume trending reports should be monitored, and report cards can be given to all providers. Ohana should increase the volume of laboratory results data. Many of the *CDC* measures rely on laboratory results data; without complete laboratory data, medical record data abstraction may be necessary to improve rates.

Member compliance with disease management recommendations and guidelines is important. Education and outreach should be targeted at high-risk, noncompliant members, and more active care/disease management programs may be indicated for these members.

Ohana reported high *ED Visits* and *Outpatient Visits* rates. While the QExA health plans may enroll sicker individuals with more chronic conditions than the QUEST health plans, Ohana should review the top diagnoses for these visits and determine if additional disease management programs or other interventions could be implemented to decrease any inappropriate use of the ED.

Validation of Performance Improvement Projects

AlohaCare

HSAG reviewed two AlohaCare PIPs: *Children's and Adolescents' Access to Primary Care* and *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form.* Table 3–36 displays the combined validation results for the two AlohaCare PIPs evaluated during 2011. This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3–36 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and an overall score across all three stages.

Table 3–36—Performance Improvement Project Validation Results *for* AlohaCare QUEST Health Plan (N=2 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–IV	100% (33/33)
Implementation	Activities V–VII	94% (16/17)
Outcomes	Activities VIII–X	72% (18/25)
Overall Percentage of Applicable Elements Scored *Met*		**89% (67/75)**

Overall, 89 percent of the evaluation elements across the two PIPs received a score of *Met*. While AlohaCare's strong performance in the Design and Implementation stages indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement, it was less successful in achieving the desired outcomes.

Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each health plan were compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

CHILDREN'S AND ADOLESCENTS' ACCESS TO PRIMARY CARE

Table 3-37 displays outcome data for AlohaCare's *Children's and Adolescents' Access to Primary Care* PIP.

Table 3-37––Performance Improvement Project Outcomes *for* Children's and Adolescents' Access to Primary Care *for* AlohaCare				
PIP Study Indicator	**Baseline Period (1/1/08–12/31/08)**	**Remeasurement 1 (1/1/09–12/31/09)**	**Remeasurement 2 (1/1/10–12/31/10)**	**Sustained Improvement**
Percentage of members aged 12–24 months with a visit to a primary care provider.	95.3%	94.3%	93.4%	No
Percentage of members aged 25 months to 6 years with a visit to a primary care provider.	84.1%	83.9%	81.8%↓*	No
Percentage of members aged 7–11 years with a visit to a primary care provider.	87.7%	85.1%↓*	84.3%	No
Percentage of members aged 12–19 years with a visit to a primary care provider.	84.5%	81.8%↓*	81.2%	No
↓* Designates a statistically significant decrease in performance over the prior measurement period (*p* value < 0.05).				

All four study indicators for the *Children's and Adolescents' Access to Primary Care* PIP demonstrated a decline in performance in Remeasurement 2. For children aged 25 months to 6 years, the decrease was statistically significant. Real or sustained improvement was not achieved for any of the indicators.

AlohaCare identified a variety of barriers and implemented system, member, and provider interventions. Lack of knowledge for both providers and their staff appeared to be the primary barrier. The health plan developed a PowerPoint presentation to train providers on EPSDT. The plan's EPSDT RN coordinator began conducting visits to PCP offices, performing medical record reviews, and educating providers and staff on the importance of EPSDT documentation. Also, the plan continued to send provider newsletters with information on appointment standards. In addition, AlohaCare initiated a pilot program with one high-volume provider, in which the parent/caregiver received a gift card for completing an EPSDT visit with the primary care provider.

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI) OR HEIGHT AND WEIGHT USING THE EPSDT FORM

Table 3-38 displays outcome data for AlohaCare's *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP. Remeasurement 1 data were reported for two of the study indicators, and baseline data were reported for the two study indicators added after the study had begun.

Table 3-38––Performance Improvement Project Outcomes *for* Assessing the Documentation of Body Mass Index (BMI) or Height and Weight using the EPSDT Form *for* AlohaCare				
PIP Study Indicator	**Baseline Period (10/1/08–9/30/09)**	**Remeasurement 1 (10/1/09–9/30/10)**	**Remeasurement 2 (10/1/10–9/30/11)**	**Sustained Improvement**
Percentage of children with weight and height recorded on the EPSDT form.	97.7%	94.2%↓*	‡	‡
Percentage of children with BMI recorded on the EPSDT form.	55.1%	62.0%↑*	‡	‡
Percentage of children with BMI percentile recorded on the EPSDT form.	33.0%¥	‡	‡	‡
Percentage of children with referral for weight counseling if BMI percentile equal to or greater than 95.	1.2%¥	‡	‡	‡

‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.
↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).
↓* Designates a statistically significant decrease in performance over the prior measurement period (*p* value < 0.05).
¥ Baseline period was 10/1/09–9/30/10; study indicator was initiated a year after the study began.

Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the noted improvement is not due to chance. For the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP, the results were mixed. The documentation of height and weight indicator decreased by a statistically significant amount, while the recorded BMI indicator demonstrated a statistically significant increase. The study had not progressed to reporting Remeasurement 2 findings; therefore, sustained improvement could not be assessed.

AlohaCare identified several barriers and implemented member, provider, and system interventions to address these barriers. The health plan conducted provider and staff education, mailed newsletters, created nutrition and physical activity posters to disseminate to the providers and throughout the community, and standardized the data being entered into the EPSDT form. AlohaCare now has a staff member assigned to complete data entry to ensure data completeness; however, this intervention was not implemented until July 2010. The impact of this intervention will not be formally reported until the next PIP measurement period; however, the health plan is encouraged to conduct interim evaluations of the success of this intervention to assess its effectiveness across the targeted study population and to ensure it is achieving the desired improvement.

Conclusions and Recommendations

Overall, both PIPs received a *Met* validation status, which represented an area of strength for AlohaCare and provided confidence in the technical aspects of the studies. The performance on these PIPs suggests a thorough application of the PIP Design stage. The sound study design of the PIPs created the foundation for the health plan to progress to subsequent PIP stages—i.e.,

implementing improvement strategies and accurately assessing study outcomes. The health plan appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the studies properly defined and collected the necessary data to produce accurate study indicator rates. Furthermore, in the Outcomes stage, AlohaCare properly analyzed the results.

Neither PIP demonstrated statistically significant improvement for all study indicators. To increase the measurable effects of its quality improvement activities, AlohaCare should ensure that the barriers identified are specific to the health plan's population and that targeted interventions are implemented that directly address those barriers. While AlohaCare exhibited a strong application of the key steps necessary for ensuring improvement, the health plan did not document other methods in addition to brainstorming sessions to identify barriers. For example, data mining and conducting focus groups would have helped to identify barriers specific to the health plan. Furthermore, AlohaCare did not provide evidence of a subgroup analysis to determine if any subgroup within its population had a disproportionately lower rate that negatively affected the overall rates. For example, did rates differ by zip code, gender, race/ethnicity, age, etc.? This "drill-down" type of analysis should be conducted both before and after the implementation of any intervention to determine if the intervention was successful. AlohaCare could then target its interventions to those subgroups with the lowest rates, which would enable the implementation of more precise, concentrated interventions.

Overall, HSAG recommends that AlohaCare do the following:

- Identify study outcome barriers specific to the AlohaCare population. Barriers should be identified through analyses and then prioritized, based on the health plan's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which interventions have not produced the desired effect.
- Conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. The health plan should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the health plan in identifying and eliminating barriers that impede improvement. AlohaCare should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.
- Complete all necessary documentation in the annual PIP submission process and not rely on the ability to resubmit.

HMSA

HSAG reviewed two PIPs for HMSA: *Well-Child Visits in the First 15 Months of Life for QUEST Members* and *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form.* This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-39 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and an overall score across all three stages.

Table 3-39––Performance Improvement Project Validation Results *for* Hawaii Medical Service Association QUEST Health Plan (N=2 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–IV	100% (33/33)
Implementation	Activities V–VII	100% (17/17)
Outcomes	Activities VIII–X	88% (21/24)
Overall Percentage of Applicable Elements Scored *Met*		**96% (71/74)**

Overall, 96 percent of the evaluation elements across the two PIPs received a score of *Met*. While HMSA's strong performance in the Design and Implementation phases indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement, it was less successful in achieving the desired outcomes.

Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each health plan are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE FOR QUEST MEMBERS

Table 3-40 displays outcome data for HMSA's *Well-Child Visits in the First 15 Months of Life for QUEST Members* PIP. The plan submitted baseline through Remeasurement 1 data.

Table 3-40––Performance Improvement Project Outcomes *for* Well-Child Visits in the First 15 Months of Life for QUEST Members *for* Hawaii Medical Service Association QUEST Health Plan				
PIP Study Indicator	**Baseline Period (1/1/08–12/31/08)**	**Remeasurement 1 (1/1/09–12/31/09)**	**Remeasurement 2 (1/1/10–12/31/10)**	**Sustained Improvement**
The percentage of members who turned 15 months during the measurement period who had 6 or more well-child visits.	49.8%	56.8%↑*	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.				
↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).				

For the *Well-Child Visits in the First 15 Months of Life for QUEST Members* PIP, the percentage of members with six or more well-child visits during the first 15 months of life demonstrated a statistically significant increase of 7.0 percentage points (*p* value <0.0001).

For the *Well-Child Visits in the First 15 Months of Life for QUEST Members* PIP, HMSA reported that providers put a high priority on well child visits for children under two years; therefore, interventions were developed on supporting parental and caregiver participation in scheduling visits by providing reminder letters and phone calls. The plan did not document any provider or system-level barrier. HMSA should document all barriers related to this measure and conduct additional analyses to sustain the improvement achieved.

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI) OR HEIGHT AND WEIGHT USING THE EPSDT FORM

Table 3-41 displays outcome data for HMSA's *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP. The plan submitted baseline through Remeasurement 1 data.

Table 3-41––Performance Improvement Project Outcomes *for* Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form *for* Hawaii Medical Service Association QUEST Health Plan				
PIP Study Indicator	**Baseline Period (10/1/08–9/30/09)**	**Remeasurement 1 (10/1/09–9/30/10)**	**Remeasurement 2 (10/1/10–9/30/11)**	**Sustained Improvement**
Percentage of children with weight and height recorded on the EPSDT form.	83.5%	98.5%↑*	‡	‡
Percentage of children with BMI recorded on the EPSDT form	48.7%	64.7%↑*	‡	‡
Percentage of children with BMI percentile recorded on the EPSDT form.	0.0%	30.4%↑*	‡	‡
Percentage of children with referral for weight counseling if BMI percentile equal to or greater than 95.	1.9%	1.0%↓*	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.				
↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).				
↓* Designates a statistically significant decrease in performance over the prior measurement period (*p* value < 0.05).				

Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the noted improvement is not due to chance. Overall, the rates for three of the four study indicators in the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP increased during the most recent measurement period and all three increases were statistically significant (*p* value<0.0001). The fourth study indicator demonstrated a statistically significant decrease of 0.9 percentage points (*p* value<0.0001).

HMSA documented that it conducted a barrier/analysis; however, it did not specify the type of causal/barrier analysis tools used. The plan identified "lack of knowledge and understanding" for both members and providers as the primary barrier. HMSA implemented limited interventions for the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP. Member and provider education were documented; however, no interventions were implemented to address barriers associated with the low referral rate. HMSA plans to implement interventions in the next measurement period to address performance in this area.

Conclusions and Recommendations

The two PIPs submitted by HMSA received an overall *Met* validation status, which represented an area of strength for HMSA and provided confidence in the technical aspects of the studies. The performance on these PIPs suggests a thorough application of the PIP Design stage and the development and implementation of appropriate interventions. The sound study design of the PIPs created the foundation for the health plan to progress to subsequent PIP stages—i.e., implementing improvement strategies and accurately assessing study outcomes. HMSA's PIP documentation provided evidence that the plan appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the studies properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, HMSA documented appropriate improvement strategies that were targeted to overcome barriers identified by the plan. Targeted interventions are critical for bringing about improvement in performance improvement projects and should be developed to specifically address and overcome barriers. Lastly, in the Outcomes stage, HMSA properly analyzed and interpreted the results according to its data analysis plan.

While HMSA exhibited strong application of the key steps necessary for bringing about improvement, the health plan did not document a comprehensive list of other methods to identify barriers that impede interventions from increasing outcome rates. Other methods may include subgroup analyses that assist in identifying subgroups within the population that have a disproportionately lower rate for well-child visits or obesity referrals. For example, HMSA could evaluate whether rates differ by geographic region, gender, age, etc., then target interventions to those subgroups with the lowest rates. This would allow better implementation of more precise, concentrated interventions to bring about real improvement.

Overall, HSAG recommends that HMSA do the following:

- Build upon the existing momentum for improving well-child visit rates and obesity documentation and referrals and implement new and/or enhanced quality improvement interventions for these PIPs.

- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.
- Identify study outcome barriers specific to the interventions already implemented. Barriers should be identified through analyses and then prioritized, based on HMSA's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- Conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. HMSA should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the health plan in identifying and eliminating barriers that impede improvement. The plan should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.
- Complete all necessary documentation in the annual PIP submission process and not rely on the ability to resubmit.

Kaiser

HSAG reviewed two Kaiser PIPs: *Access to Care* and *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form.* Table 3-42 displays the combined validation results for the two Kaiser PIPs evaluated during 2011. This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-42 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-42––Performance Improvement Project Validation Results *for* Kaiser Permanente Hawaii QUEST Health Plan (N=2 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–IV	100% (32/32)
Implementation	Activities V–VII	100% (25/25)
Outcomes	Activities VIII–X	81% (21/26)
Overall Percentage of Applicable Elements Scored *Met*		**94% (78/83)**

Overall, 94 percent of the evaluation elements across the two PIPs received a score of *Met*. While Kaiser's strong performance in the Design and Implementation phases indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement, it was less successful in achieving the desired outcomes.

Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each health plan are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

ACCESS TO CARE

Table 3-43 displays outcome data for Kaiser's PIP. The plan submitted baseline through Remeasurement 2 for the *Access to Care* PIP.

Table 3-43––Performance Improvement Project Outcomes *for* Access to Care *for* Kaiser Permanente Hawaii QUEST Health Plan

PIP Study Indicator	Baseline Period (1/1/08–4/30/08)	Remeasurement 1 (1/1/09–4/30/09)	Remeasurement 2 (1/1/10–4/30/10)	Sustained Improvement
The percentage of members who answered Always or Usually to the CAHPS question #6 (In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you wanted?)	78.2%	76.3%	80.9%	No

For the *Access to Care* PIP, the percentage of members who answered "Always" or "Usually" to the CAHPS question, "In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you wanted?" demonstrated an increase in performance, although the increase was not statistically significant.

For the *Access to Care* PIP, the health plan conducted a formal analysis that included a causal/barrier analysis, and the results were discussed by the region's quality committee. Kaiser addressed member, provider, and system barriers through a variety of interventions. One of these interventions involved the health plan's ongoing promotion to encourage members, as well as providers and staff, to sign up to receive e-mails, online communication, and education from kp.org. Sign-up promotion included flyers, banners, and posters throughout the facilities, and recommendations were made to the providers to use this e-mail system. Another intervention was adopting the Clinic Ownership of Same Day Demand policy. This policy ensures that when a patient contacts a clinic, he or she is seen in an appropriate setting. Kaiser also created the Regional

Accessibility of Services policy containing formal standards to ensure accessibility of primary care and behavioral health services and to ensure that there are an adequate number of practitioners.

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI) OR HEIGHT AND WEIGHT USING THE EPSDT FORM

Table 3-44 displays outcome data for Kaiser's PIP. The plan submitted baseline through Remeasurement 1 data for the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP.

Table 3-44––Performance Improvement Project Outcomes
***for* Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form**
***for* Kaiser Permanente Hawaii QUEST Health Plan**

PIP Study Indicator	Baseline Period (10/1/08–9/30/09)	Remeasurement 1 (10/1/09–9/30/10)	Remeasurement 2 (10/1/10–9/30/11)	Sustained Improvement
Percentage of children with weight and height recorded on the EPSDT form.	98.2%	99.0%↑*	‡	‡
Percentage of children with BMI recorded on the EPSDT form.	98.3%	99.1%	‡	‡
Percentage of children with BMI percentile recorded on the EPSDT form.	69.0%	74.0%↑*	‡	‡
Percentage of children with referral for weight counseling if BMI percentile equal to or greater than 95.	17.5%	100.0%↑*	‡	‡

‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.
↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the noted improvement is not due to chance. Overall, the rates for all four study indicators in the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP increased during the most recent measurement period and, for three indicators, the increases were statistically significant (*p* value <0.0001).

For the *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* PIP, the health plan implemented provider and system interventions. One of the interventions implemented was EPSDT compliance monitoring and education. This included a monthly chart review for compliance with documentation of all EPSDT elements, including height and weight. The results of this monitoring were communicated via e-mail and involved clinic supervisors and chiefs, as well as one-on-one follow-up with individual practitioners. Kaiser's QUEST medical director assisted in reinforcement of requirements. The plan also began including physician education during the office visit as a "referral" which led to the improved results for the referral study indicator.

Conclusions and Recommendations

The two PIPs submitted by Kaiser received an overall *Met* validation status, which represented an area of strength for Kaiser and provided confidence in the technical aspects of the studies. The performance on these PIPs suggests a thorough application of the PIP Design stage and the development and implementation of appropriate interventions. The sound study design of the PIPs created the foundation for Kaiser to progress to subsequent PIP stages—i.e., implementing improvement strategies and accurately assessing study outcomes. Kaiser's PIP documentation provided evidence that the plan appropriately conducted the data collection and improvement strategy activities of the Implementation stage. These activities ensured that the studies properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, Kaiser documented appropriate improvement strategies that were targeted to overcome barriers identified by the health plan. Targeted interventions are critical for realizing improvement in performance improvement studies and should be developed to specifically address and overcome barriers.

While Kaiser exhibited strong application of the key steps necessary for bringing about improvement, the health plan did not document a comprehensive list of other methods to identify barriers that impede interventions from increasing outcome rates. Other methods may include subgroup analyses that assist in identifying subgroups within the population that have a disproportionately lower rate for any of the study outcomes. For example, Kaiser could evaluate whether rates differ by geographic region, gender, age, etc., then target interventions to those subgroups with the lowest rates. This would allow better implementation of more precise, concentrated interventions to bring about real improvement.

Overall, HSAG recommends that Kaiser do the following:

- Build upon the existing momentum for improving rates and implement new and/or enhanced quality improvement interventions for these PIPs.
- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.
- Identify study outcome barriers specific to the interventions already implemented. Barriers should be identified through analyses and then prioritized, based on the health plan's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- Conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. The plan should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the plan in identifying and eliminating barriers that impede improvement. The plan should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.

- Complete all necessary documentation in the annual PIP submission process and not rely on the ability to resubmit.

Evercare

HSAG reviewed two Evercare PIPs: *Diabetes Care* and *Assessing the Documentation of Body Mass Index (BMI)*. Table 3-45 displays the combined validation results for the two Evercare PIPs evaluated during 2011. This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-45 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-45––Performance Improvement Project Validation Results *for* Evercare QExA Health Plan (N=2 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–IV	100% (34/34)
Implementation	Activities V–VII	100% (36/36)
Outcomes	Activities VIII–X	Not Assessed
Overall Percentage of Applicable Elements Scored *Met*		**100% (70/70)**

Overall, 100 percent of the evaluation elements across the two PIPs received a score of *Met*. Evercare's strong performance in the Design and Implementation phases indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement.

Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each health plan are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

DIABETES CARE

Evercare had not progressed to the point of reporting baseline data.

Table 3-46––Performance Improvement Project Outcomes *for* ***Diabetes Care*** *for* **Evercare QExA Health Plan**				
PIP Study Indicator	**Baseline Period (1/1/10–12/31/10)**	**Remeasurement 1 (1/1/11–12/31/11)**	**Remeasurement 2 (1/1/12–12/31/12)**	**Sustained Improvement**
Percentage of members 18–75 years of age who received at least one HbA1c screening during the measurement year.	‡	‡	‡	‡
Percentage of members 18–75 years of age who had a dilated retinal eye exam or who had a negative retinal exam performed during the measurement year.	‡	‡	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.				

Evercare completed a fish bone diagram to determine its barriers. Through this barrier analysis process, the health plan identified both member and provider barriers. For the *Diabetes Care* PIP, knowledge deficits regarding the importance of regular exams were the focus of member interventions; and lack of knowledge regarding clinical practice guidelines was the focus of provider interventions. In 2010, Evercare disseminated letters to members identified as having diabetes, explaining the disease management program and welcoming them to join. The health plan also mailed newsletters containing information about diabetic retinopathy and providing the Web site link to information on diabetes. For providers, diabetic medical care clinical practice guideline standards were posted on the Web site, and the health plan mailed provider letters explaining its disease management program, along with clinical practice guidelines.

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI)

Evercare had not progressed to the point of reporting baseline data.

Table 3-47––Performance Improvement Project Outcomes *for* ***Assessing the Documentation of Body Mass Index (BMI)*** *for* **Evercare QExA Health Plan**				
PIP Study Indicator	**Baseline Period (1/1/10–12/31/10)**	**Remeasurement 1 (1/1/11–12/31/11)**	**Remeasurement 2 (1/1/12–12/31/12)**	**Sustained Improvement**
Percentage of eligible members 3–17 years of age who had evidence of BMI percentile documented during the measurement year.	‡	‡	‡	‡
Percentage of eligible members 18–74 years of age who had evidence of BMI percentile documented during the measurement year.	‡	‡	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.				

For the *Assessing the Documentation of Body Mass Index (BMI)* PIP, the plan focused on member and provider education. Evercare adopted clinical practice guidelines on prevention of pediatric

overweight and obesity, treatment of obesity, and tools for calculating BMI and posted these guidelines on the Web site for providers. The health plan mailed provider letters that included the importance of including BMI in patient assessments, and a targeted provider letter specific to the disease management program. For its members, Evercare mailed a variety of newsletters that addressed the topics of healthy foods, and the importance of knowing one's BMI for healthy weight. Evercare also donated Sesame Street Reading Corners to federally qualified health centers (FQHCs) on all islands, equipped with child-sized tables and chairs, and posters and books on healthy eating and nutrition. The health plan also disseminated letters to members identified as obese, explaining the disease management program and welcoming them to join.

Conclusions and Recommendations

Both PIPs received an overall *Met* validation status, which represented an area of strength for Evercare and provided confidence in the technical aspects of the studies. The performance on these PIPs suggests a thorough application of the PIP Design and Implementation stages. The sound study design of the PIPs created the foundation for Evercare to progress to subsequent PIP stages—i.e., implementing improvement strategies. Evercare appropriately conducted the sampling, data collection and improvement strategy activities of the Implementation stage. These activities ensured that the studies properly defined and collected the necessary data to produce accurate study indicator rates, and that study outcomes could improve.

While Evercare exhibited a strong application of the key steps necessary for ensuring improvement, the health plan did not document other methods in addition to completing a fish bone diagram to identify barriers. For example, data mining and conducting focus groups would have helped to identify barriers specific to the health plan.

Overall, HSAG recommends that Evercare do the following:

- Identify study outcome barriers specific to the Evercare population. Barriers should be identified through analyses and then prioritized, based on the health plan's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- Conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. The health plan should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the health plan in identifying and eliminating barriers that impede improvement. Evercare should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.
- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.
- Complete all necessary documentation in the annual PIP submission process and not rely on the ability to resubmit.

Ohana

HSAG reviewed two Ohana PIPs: *Improving Comprehensive Diabetes Care* and *Improving Care for Members With Obesity*. Table 3-48 displays the combined validation results for the two Ohana PIPs evaluated during 2011. This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-48 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-48––Performance Improvement Project Validation Results *for* Ohana QExA Health Plan (N=2 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–IV	88% (29/33)
Implementation	Activities V–VII	81% (30/37)
Outcomes	Activities VIII–X	50% (5/10)
Overall Percentage of Applicable Elements Scored *Met*		**80% (64/80)**

Overall, 80 percent of the evaluation elements across the two PIPs received a score of *Met*. For the Implementation stage, Ohana was scored down for providing conflicting information regarding sampling techniques. After receiving technical assistance from HSAG, Ohana did not correct the sampling issues in the *Improving Care for Members With Obesity* PIP, resulting in only 50 percent of the applicable evaluation elements receiving a *Met* score for Activity V. Consequently, the low score for Activity V lowered the score for the Implementation stage to 81 percent. Ohana's overall performance in the Design and Implementation phases indicated that the *Diabetes Care* PIP was designed and implemented appropriately to measure outcomes and improvement. In the Outcomes stage, both PIPs were validated through Activity VIII. Real and sustained improvement could not be assessed since only baseline data were reported for both PIPs. In Activity VIII, Ohana did not compare the baseline results to its goals for either PIP. In addition, for the *Improving Care for Members With Obesity* PIP, the results were not generalizable to Ohana's population since the sampling techniques were not properly documented. The deficiencies in Activity VIII resulted in a score of only 50 percent for the Outcomes stage.

Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each health plan are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

IMPROVING COMPREHENSIVE DIABETES CARE

Table 3-49 displays outcome baseline data for Ohana's *Diabetes Care* PIP.

Table 3-49––PIP Validation Overall Score *for* Improving Comprehensive Diabetes Care *for* Ohana QExA Health Plan

PIP Study Indicator	Baseline Period (2/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Sustained Improvement
Percentage of members who received an HbA1c screening during the measurement year.	79.6%	‡	‡	‡
Percentage of members who had at least one LDL-C screening during the measurement year.	74.8%	‡	‡	‡
Percentage of members who had at least one retinal eye exam during the measurement year.	40.1%	‡	‡	‡

‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.

For the *Diabetes Care* PIP, Ohana reported baseline rates for three study indicators. Over 79 percent of the members received an HbA1c screening, while only 40.1 percent of the eligible members received a retinal eye exam. All three rates were below the HEDIS 2009 Medicaid 75th percentiles which were established as Ohana's goals.

Ohana performed literature searches and interviewed staff members at community health centers to identify improvement barriers. Ohana did not provide a detailed process for the selection of the interventions or how it would evaluate the effectiveness of the interventions.

Ohana introduced numerous member, provider and system interventions to address the current diabetes care rates. These interventions included hiring two full-time health education specialists, distributing diabetes management practice guidelines to providers, distributing provider toolkits, mailing education packets to members willing to join diabetes programs, and community outreach.

IMPROVING CARE FOR MEMBERS WITH OBESITY

Table 3-50 displays outcome baseline data for Ohana's *Improving Care for Members With Obesity* PIP.

Table 3-50––Performance Improvement Project Outcomes *for* ***Improving Care for Members With Obesity*** *for* Ohana QExA Health Plan				
PIP Study Indicator	**Baseline Period (2/1/09–12/31/09)**	**Remeasurement 1 (1/1/10–12/31/10)**	**Remeasurement 2 (1/1/11–12/31/11)**	**Sustained Improvement**
Percentage of obese members who were referred to an obesity management program.	5.2%	‡	‡	‡
Percentage of members who attended an obesity management program, received a behavioral health assessment, or received behavioral health treatment.	£	‡	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement. £ Rates were not accurate as reported.				

Ohana reported a baseline rate of 5.2 percent of obese members who were referred to an obesity management program. The rate for the second indicator was calculated incorrectly and, therefore, is not displayed in the table.

Ohana included a fishbone diagram as part of its barrier analysis; however, it did not provide additional details related to the barrier analysis process or other methods that may have been implemented as part of the improvement strategy.

For the *Obesity* PIP, Ohana began calling members to introduce the obesity program but acknowledged a need to modify the language on the calling screens. The health plan also identified a need to refine its process for pulling the claims data to ensure it accurately identifies members diagnosed as obese. Ohana attributed the low results to lack of current community support, lack of member incentive programs for obesity, and the inability to track members attending free exercise or obesity training venues. Knowing this, Ohana plans to focus on the following:

- Increase community resources listed in member packets.
- Create a pilot program initiative to pay for gym memberships and track improvements for severely obese members.
- Work with behavioral health providers to develop educational handouts.
- Develop an Obesity Fast Guide to distribute to members.
- Develop other tools to measure and monitor improvements.
- Use the pseudo claims database to input BMI data from EPSDT forms to track children with obesity and refer directly to disease management.
- Create a program to give away scales and/or tape measures to members who do not have this equipment and cannot purchase it.

Conclusions and Recommendations

Ohana appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the studies properly defined and had the ability to collect the necessary data to produce accurate study indicator rates. Additionally, Ohana correctly documented improvement strategies, an activity which ensured that study outcomes could improve.

While Ohana exhibited a strong application of the key steps necessary for ensuring improvement, the health plan did not provide detailed documentation of its methods. For example, data mining and conducting focus groups would help to identify barriers specific to the health plan. Furthermore, the health plan did not provide evidence of a subgroup analysis to determine if any subgroup within its population had a disproportionately lower rate that negatively affected the overall rates. For example, did rates differ by zip code, gender, race/ethnicity, age, etc.? This "drill-down" type of analysis should be conducted both before and after the implementation of any intervention to determine if the intervention was successful. Ohana could then target its interventions to those subgroups with the lowest rates, which would enable the implementation of more precise, concentrated interventions.

Overall, HSAG recommends that Ohana do the following:

- Incorporate the recommendations provided in the PIP Validation Tool and during technical assistance before the PIP is resubmitted.
- Complete all necessary documentation in the annual PIP submission process and not rely on the ability to resubmit.
- Provide more detailed documentation of the process used to identify barriers, develop interventions, and evaluate the effectiveness of those interventions.
- Identify study outcome barriers specific to the Ohana population. Barriers should be identified through analyses and then prioritized, based on the health plan's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- Conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. Ohana should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist Ohana in identifying and eliminating barriers that impede improvement. The health plan should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.
- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)-Child Survey

AlohaCare

Results

Table 3-51 presents the 2009 and 2011 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), and overall 2011 member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures for AlohaCare.

Table 3-51—Child Medicaid CAHPS Results *for* AlohaCare

Measure	2009 Rates	2011 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	65.0%	67.4%	★★★
Rating of All Health Care	61.9%	58.3%	★★
Rating of Personal Doctor	70.6%	71.9%	★★★
Rating of Specialist Seen Most Often	NA	NA	NA
Composite Measures			
Getting Needed Care	47.0%	NA	NA
Getting Care Quickly	61.1%	59.7%	★
How Well Doctors Communicate	70.6%	70.1%	★
Customer Service	NA	NA	NA
Shared Decision Making	59.9%	64.1%	★★

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

▲ indicates the 2011 score is significantly higher than the 2009 score
▼ indicates the 2011 score is significantly lower than the 2009 score

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that AlohaCare scored:

- At or between the 50th and 74th percentiles on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- At or between the 25th and 49th percentiles on two measures: *Rating of All Health Care* and *Shared Decision Making*.
- Below the 25th percentile on two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.

A comparison of AlohaCare's 2009 scores to its corresponding 2011 scores revealed that AlohaCare did not score significantly higher or lower in 2011 than in 2009 on any of the measures.

Conclusions and Recommendations

Based on an evaluation of AlohaCare's results, the priority areas identified were: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. The following are recommendations of best practices and other proven strategies that can be used or adapted by the health plan to target improvement in each of these areas.

GETTING CARE QUICKLY

- **Open Access Scheduling**—Open access scheduling models allow for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model involves leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or a clinical service (i.e., the time it takes to complete various parts of the visit/service). This type of analysis can help providers identify problem areas, including steps that can be eliminated or steps that can be performed more efficiently. A patient flow analysis should also include measuring the amount of time it takes to complete a scheduled visit for various appointment types.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Nurse Advice Help Line**—Health plans can establish a nurse advice help line to assist members in seeking the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit can be directed to the help line, where nurses can assess their situation and provide advice for receiving care.

HOW WELL DOCTORS COMMUNICATE

- **Communication Tools for Patients**—Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
- **Improve Health Literacy**—Health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions should be revised and developed in new formats to aid patients' understanding of the health information that is being presented to them. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

SHARED DECISION MAKING

- **Skills Training for Physicians**—Health plans should encourage skills training for all physicians. One key to a successful shared decision-making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; understanding patients' preferences and needs; and improving communication skills.
- **Shared Decision Making Materials**—Physicians will be able to better encourage their patients to participate if the health plan provides the physicians with literature that conveys the importance of the shared decision-making model. In addition, materials such as health care goal-setting handouts and forms can assist physicians in facilitating the shared decision-making process with their patients. Health plans can also provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.
- **Patient Education**—Health plans can provide members with educational literature and information. Items such as brochures on a specific medical condition and a copy of the assessment and plan portions of the physician's progress notes together with a glossary of terms can empower patients with the information they need to ask informed questions and express personal values and opinions about their condition and treatment options.

HMSA

Results

Table 3-52 presents the 2009 and 2011 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), and overall 2011 member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures for HMSA.

Table 3-52—Child Medicaid CAHPS Results *for* HMSA

Measure	2009 Rates	2011 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	69.6%	69.2%	★★★★
Rating of All Health Care	60.3%	63.4%	★★★★
Rating of Personal Doctor	70.4%	71.0%	★★★★
Rating of Specialist Seen Most Often	60.4%	NA	NA
Composite Measures			
Getting Needed Care	52.5%	50.8%	★★
Getting Care Quickly	61.9%	65.3%	★
How Well Doctors Communicate	70.9%	73.0%	★★★
Customer Service	NA	NA	NA
Shared Decision Making	62.6%	68.7%	★★★★

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

▲ indicates the 2011 score is significantly higher than the 2009 score
▼ indicates the 2011 score is significantly lower than the 2009 score

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that HMSA scored:

- At or between the 75th and 89th percentiles on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Shared Decision Making*.
- At or between the 50th and 74th percentiles on one measure, *How Well Doctors Communicate*.
- At or between the 25th and 49th percentiles on one measure, *Getting Needed Care*.
- Below the 25th percentile on one measure, *Getting Care Quickly*.

A comparison of HMSA's 2009 scores to its corresponding 2011 scores revealed that HSMA did not score significantly higher or lower in 2011 than in 2009 on any of the measures.

Conclusions and Recommendations

Based on an evaluation of HMSA's results, the priority areas identified were: *Getting Care Quickly*, *Getting Needed Care*, and *How Well Doctors Communicate*. The following are recommendations of best practices and other proven strategies that can be used or adapted by the health plan to target improvement in these areas.

GETTING CARE QUICKLY

- **Open Access Scheduling**—Open access scheduling models allow for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model involves leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or a clinical service (i.e., the time it takes to complete various parts of the visit/service). This type of analysis can help providers identify problem areas, including steps that can be eliminated or steps that can be performed more efficiently. A patient flow analysis should also include measuring the amount of time it takes to complete a scheduled visit for various appointment types.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Nurse Advice Help Line**—Health plans can establish a nurse advice help line to assist members in seeking the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit can be directed to the help line, where nurses can assess their situation and provide advice for receiving care.

GETTING NEEDED CARE

- **Enhanced Provider Directories**—Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production or updating of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be further enhanced by developing and publishing physician-level performance measures that give patients the ability to compare providers and make decisions accordingly.

- **Appropriate Health Care Providers**—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from appropriate health care providers is imperative to assessing quality of care.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral and allow providers access to a standardized referral form.

HOW WELL DOCTORS COMMUNICATE

- **Communication Tools for Patients**—Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
- **Improve Health Literacy**—Health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions should be revised and developed in new formats to aid patients' understanding of the health information that is being presented to them. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

Kaiser

Results

Table 3-53 presents the 2009 and 2011 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), and overall 2011 member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures for Kaiser.

Table 3-53—Child Medicaid CAHPS Results *for* Kaiser

Measure	2009 Rates	2011 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	68.2%	73.4% ▲	★★★★★
Rating of All Health Care	61.7%	63.3%	★★★★
Rating of Personal Doctor	78.7%	78.5%	★★★★★
Rating of Specialist Seen Most Often	68.5%	70.6%	★★★★
Composite Measures			
Getting Needed Care	54.0%	52.1%	★★
Getting Care Quickly	63.3%	69.1% ▲	★★
How Well Doctors Communicate	78.7%	81.5%	★★★★★
Customer Service	56.0%	NA	NA
Shared Decision Making	69.8%	70.2%	★★★★★

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

▲ indicates the 2011 score is significantly higher than the 2009 score
▼ indicates the 2011 score is significantly lower than the 2009 score

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that Kaiser scored:

- At or above the 90th percentile on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- At or between the 75th and 89th percentiles on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often*.
- At or between the 25th and 49th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly*.

A comparison of Kaiser's 2009 scores to its corresponding 2011 scores revealed that Kaiser scored significantly higher in 2011 than in 2009 on two measures: *Rating of Health Plan* and *Getting Care Quickly*.

Conclusions and Recommendations

Based on an evaluation of Kaiser's results, the priority areas identified were: *Getting Care Quickly*, *Getting Needed Care*, and *Rating of Specialist Seen Most Often*. The following are recommendations of best practices and other proven strategies that can be used or adapted by the health plan to target improvement in these areas.

GETTING CARE QUICKLY

- **Open Access Scheduling**—Open access scheduling models allow for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model involves leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or a clinical service (i.e., the time it takes to complete various parts of the visit/service). This type of analysis can help providers identify problem areas, including steps that can be eliminated or steps that can be performed more efficiently. A patient flow analysis should also include measuring the amount of time it takes to complete a scheduled visit for various appointment types.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Nurse Advice Help Line**—Health plans can establish a nurse advice help line to assist members in seeking the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit can be directed to the help line, where nurses can assess their situation and provide advice for receiving care.

GETTING NEEDED CARE

- **Enhanced Provider Directories**—Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production or updating of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be further enhanced by developing and publishing physician-level performance measures that give patients the ability to compare providers and make decisions accordingly.

- **Appropriate Health Care Providers**—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from appropriate health care providers is imperative to assessing quality of care.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral and allow providers access to a standardized referral form.

RATING OF SPECIALIST SEEN MOST OFTEN

- **Telemedicine**—Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. This allows for the local provider to be more involved in the consultation process and more informed about the care the patient is receiving.
- **Skills Training for Specialists**—Health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
- **Planned Visit Management**—Health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. Furthermore, follow-up with patients should be carried out to ensure that they understand all information provided to them during their visit.

Evercare

Results

Table 3-54 presents the 2011 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), and overall member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures for Evercare.

Table 3-54—Child Medicaid CAHPS Results *for* Evercare

Measure	2011 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	43.4%	★
Rating of All Health Care	49.0%	★
Rating of Personal Doctor	69.8%	★★★
Rating of Specialist Seen Most Often	67.4%	★★★
Composite Measures		
Getting Needed Care	38.5%	★
Getting Care Quickly	58.0%	★
How Well Doctors Communicate	74.4%	★★★
Customer Service	NA	NA
Shared Decision Making	68.8%	★★★

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that Evercare scored:

- At or between the 50th and 74th percentiles on four measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- Below the 25th percentile on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*.

Conclusions and Recommendations

Based on an evaluation of Evercare's results, the priority areas identified were: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care*.[3-1] The following are recommendations of best practices and other proven strategies that can be used or adapted by the health plan to target improvement in each of these areas.

RATING OF HEALTH PLAN

- **Health Plan Operations**—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services) for members that provide the health plan's health care "products." A microsystems approach focuses on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.
- **Online Patient Portal**—A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide quality improvement (QI) initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives.

RATING OF ALL HEALTH CARE

- **Access to Care**—Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.
- **Health Care Experiences**—To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.
- **Patient and Family Advisory Councils**—Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

[3-1] *Getting Care Quickly* was also identified as a potential top priority, but further analyses revealed no current key drivers on which to focus. Therefore, HSAG recommends that Evercare focus on the key drivers of satisfaction for *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care*.

GETTING NEEDED CARE

- **Enhanced Provider Directories**—Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production or updating of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be further enhanced by developing and publishing physician-level performance measures that give patients the ability to compare providers and make decisions accordingly.
- **Appropriate Health Care Providers**—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allow providers access to a standardized referral form.
- **Facilitate Coordinated Care**—Coordinated care is most effective when service coordinators and providers organize their efforts to deliver the same message to members. Coaching service coordinators to keep providers informed about the interventions their patients are receiving can help engage providers in the care coordination process. Additionally, providing patient registries or clinical information systems that allow providers and service coordinators to enter information on patients (e.g., notes from a telephone call or a physician visit) can help reduce duplication of services and facilitate care coordination.

Ohana

Results

Table 3-55 presents the 2011 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), and overall member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures for Ohana.

Table 3-55—Child Medicaid CAHPS Results *for* Ohana

Measure	2011 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	40.9%	★
Rating of All Health Care	47.6%	★
Rating of Personal Doctor	67.8%	★
Rating of Specialist Seen Most Often	61.6%	★★
Composite Measures		
Getting Needed Care	41.6%	★
Getting Care Quickly	60.7%	★
How Well Doctors Communicate	70.8%	★
Customer Service	42.1%	★
Shared Decision Making	67.4%	★★★

NA indicates that a rate was not assigned due to there being fewer than 100 respondents.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that Ohana scored:

- At or between the 50th and 74th percentiles on one measure, *Shared Decision Making*.
- At or between the 25th and 49th percentiles on one measure, *Rating of Specialist Seen Most Often*.
- Below the 25th percentile on seven measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

Conclusions and Recommendations

Based on an evaluation of Ohana's results, the priority areas identified were: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.[3-2] The following are recommendations of best practices and other proven strategies that can be used or adapted by the health plan to target improvement in each of these areas.

RATING OF HEALTH PLAN

- **Health Plan Operations**—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services) for members that provide the health plan's health care "products." A microsystems approach focuses on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.
- **Online Patient Portal**—A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives.

RATING OF ALL HEALTH CARE

- **Access to Care**—Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.
- **Health Care Experiences**—To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.

[3-2] *Getting Care Quickly* was also identified as a potential top priority, but further analyses revealed no current key drivers on which to focus. Therefore, HSAG recommends that Ohana focus on the key drivers of satisfaction for *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, How Well Doctors Communicate, and Customer Service*.

- **Patient and Family Advisory Councils**—Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

RATING OF PERSONAL DOCTOR

- **Physician-Patient Communication**—Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.
- **Maintain Truth in Scheduling**—Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

GETTING NEEDED CARE

- **Enhanced Provider Directories**—Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production or updating of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be further enhanced by developing and publishing physician-level performance measures that give patients the ability to compare providers and make decisions accordingly.
- **Appropriate Health Care Providers**—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from appropriate health care providers is imperative to assessing quality of care.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allow providers access to a standardized referral form.
- **Facilitate Coordinated Care**—Coordinated care is most effective when service coordinators and providers organize their efforts to deliver the same message to members. Coaching service coordinators to keep providers informed about the interventions their patients are receiving can help engage providers in the care coordination process. Additionally, providing patient registries or clinical information systems that allow providers and service coordinators to enter

information on patients (e.g., notes from a telephone call or a physician visit) can help reduce duplication of services and facilitate care coordination.

HOW WELL DOCTORS COMMUNICATE

- **Communication Tools for Patients**—Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
- **Improve Health Literacy**—Health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions should be revised and developed in new formats to aid patients' understanding of the health information that is being presented to them. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

CUSTOMER SERVICE

- **Service Recovery**—A health plan can implement a service recovery program to ensure that members are provided appropriate assistance to resolve their problems. Service recovery can include listening to a patient who is upset, handing out incentives to patients who have had to wait longer than a specified time for a doctor visit, and assessing the events to identify the source of the problem.
- **Customer Service Performance Measures**—Setting plan-level customer service standards can assist in addressing issues and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.
- **Employee Training and Empowerment**—It is important for health plans and providers to ensure that customer service staff have adequate training on all pertinent business processes. In addition, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to various employees and promote timely resolution.
- **Call Centers**—An evaluation of current call center hours and practices can be conducted to determine if the hours and resources meet member needs. Additionally, members can be asked at the end of a call to complete a short survey, which can be used to determine if members are getting the help they need and identify areas for improvement.

Provider Survey

The 2011 Hawaii Provider Survey results for participating QUEST and QExA health plans are presented on the following six domains of satisfaction:

- **General Positions**—presents (1) the personal attitudes of providers toward the concept of managed care, Hawaii Med-QUEST, QUEST health plans, QExA health plans, and commercial managed care health plans; (2) providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation; and (3) providers' level of satisfaction with the timeliness of claims payments.
- **Health Plan Communication**—presents providers' satisfaction ratings with the knowledge and expertise of health plan staff and how well the health plan kept providers informed about their utilization patterns and financial performance, specifically if the providers are at financial risk.
- **Formulary**—presents providers' level of satisfaction with access to both formulary and non-formulary drugs.
- **Specialists**—presents providers' level of satisfaction with the health plans' number of specialists, range of specialists, and referral policies for specialists.
- **Providing Quality Care**—presents providers' level of satisfaction with the health plans' prior authorization process, referral process, formulary, concurrent review, discharge planning, and network of hospitals, in terms of having an impact on providers' abilities to deliver quality care.
- **Behavioral Health**—presents providers' behavioral health services practices and the frequency with which they refer patients to mental health care specialists.

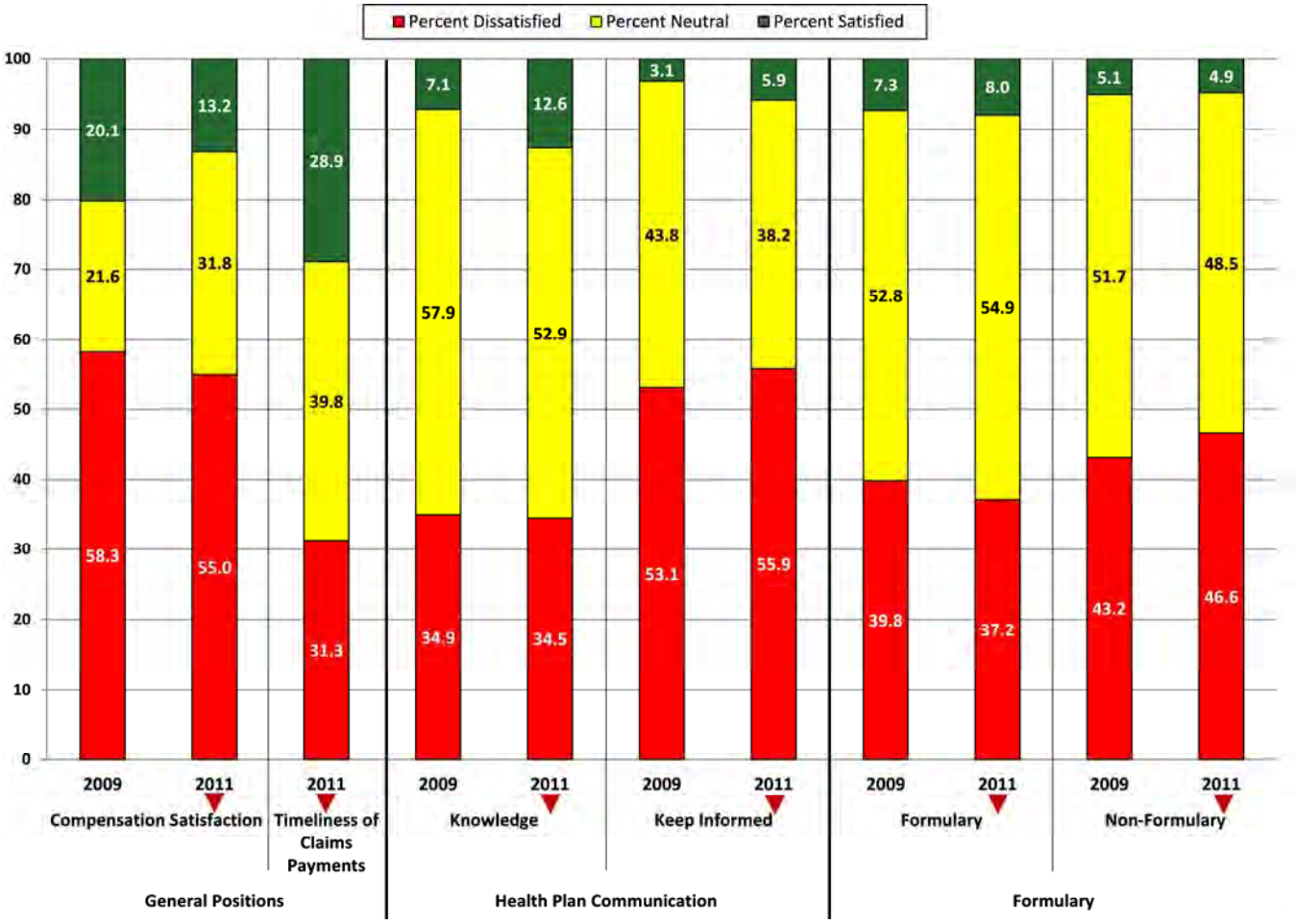
Response options to each question within these domains were classified into three response categories: satisfied, neutral, and dissatisfied.

AlohaCare

Results and Conclusions

Figure 3-1 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions, health plan communication, and formulary for AlohaCare.[3-3]

Figure 3-1—AlohaCare: General Positions, Health Plan Communication, and Formulary



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

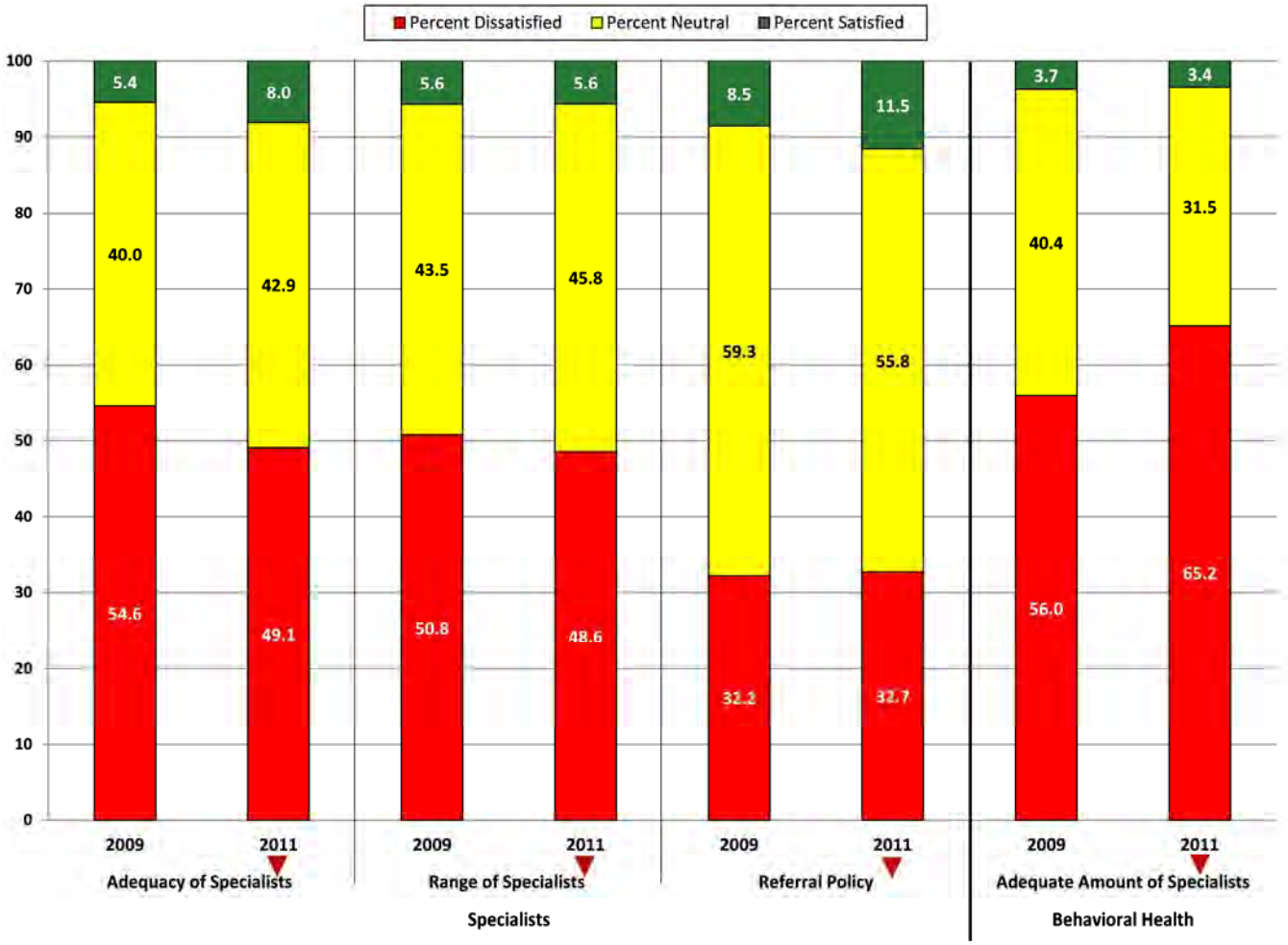
[3-3] 2009 results are not presented for the Timeliness of Claims Payments measure, since this is a new measure for 2011.

- AlohaCare's 2011 top-box rates for reimbursement/compensation and timeliness of claims payments (13.2 percent and 28.9 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans.
- AlohaCare's 2011 top-box rates for knowledge and expertise at the health plan and being kept informed about utilization patterns (12.6 percent and 5.9 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans.
- AlohaCare's 2011 top-box rates for adequacy of formulary and access to non-formulary drugs (8.0 percent and 4.9 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans.

A comparison of AlohaCare's 2009 top-box scores to its corresponding 2011 top-box scores revealed that AlohaCare did not score significantly higher or lower in 2011 than in 2009 on any of these measures.

Figure 3-2 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of specialists and behavioral health for AlohaCare.

Figure 3-2—AlohaCare: Specialists and Behavioral Health



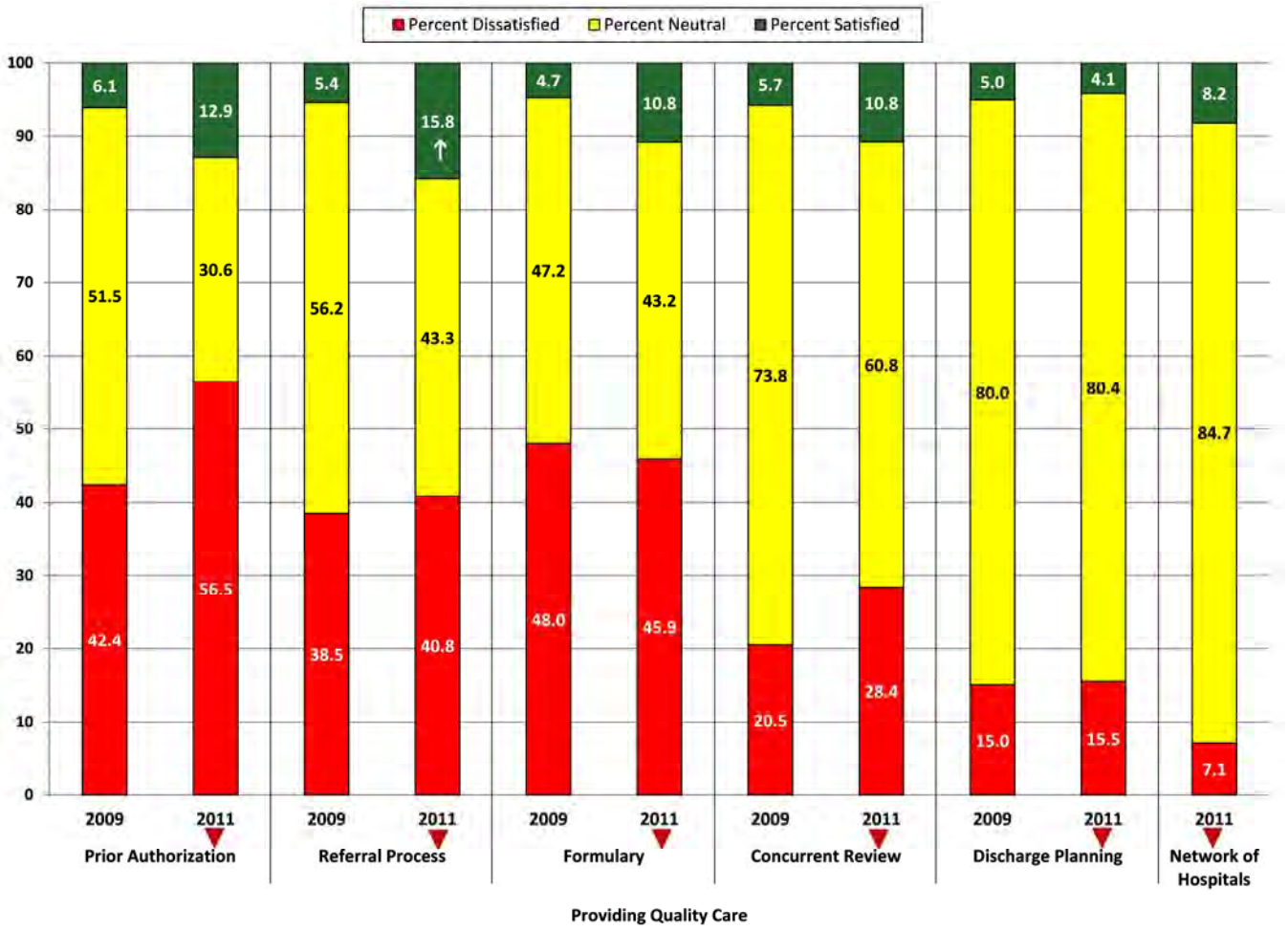
Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

- AlohaCare's 2011 top-box rates for adequacy of specialists, range of specialists, and referral policy (8.0 percent, 5.6 percent, and 11.5 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans.
- AlohaCare's 2011 top-box rate for adequate amount of behavioral health specialists (3.4 percent) was significantly lower than the aggregate of the other QUEST health plans.

A comparison of AlohaCare's 2009 top-box scores to its corresponding 2011 top-box scores revealed that AlohaCare did not score significantly higher or lower in 2011 than in 2009 on any of these measures.

Figure 3-3 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domain of providing quality care for AlohaCare.[3-4]

Figure 3-3—AlohaCare: Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

- AlohaCare's 2011 top-box rates for prior authorization process, referral process, formulary, concurrent review, discharge planning, and network of hospitals (12.9 percent, 15.8 percent, 10.8 percent, 10.8 percent, 4.1 percent, and 8.2 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans.

[3-4] 2009 results are not presented for the Network of Hospitals measure, since this is a new measure for 2011.

A comparison of AlohaCare's 2009 top-box scores to its corresponding 2011 top-box scores revealed that AlohaCare scored significantly higher in 2011 than in 2009 on the referral process measure.

Recommendations

The Provider Survey revealed that AlohaCare has several opportunities to improve provider satisfaction. HSAG has provided some potential quality improvement suggestions that AlohaCare and the MQD may use to increase satisfaction.[3-5]

- Providers consistently expressed concerns about the knowledge and expertise of the staff at the health plan. AlohaCare can provide educational sessions to ensure staff members are up to date and well informed about information on patient care and services requested by providers. Staff members should be knowledgeable of basic information such as patient benefits, claims and billing, authorization and utilization management procedures, and other processes related to health plan operations that support providers.
- Opportunities exist based on providers' feedback to ensure that the health plan has an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary. The MQD could review the formulary list periodically to ensure that the list is updated to include essential medicines and drugs that follow standard treatment guidelines. The MQD should consider working with the health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- If not already available, AlohaCare should use information technology to automate its authorization and referral processes. Automation of these processes can help facilitate patient care and allow for efficient communication with providers. An example includes use of an online authorization and referral submission tool that allows providers to submit requests and receive approvals electronically. Automating these processes can also (1) minimize the number of human touches required for patient authorization, referral, and claims processing; (2) reduce the time required for providers to receive an authorization; (3) improve the timeliness of patient care; and (4) improve claims processing.
- AlohaCare should consider conducting an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization are approved. For those specialty categories and medical services that have high approval rates, AlohaCare could investigate the possibility of no longer requiring a referral or authorization in order for these processes to have a more positive impact on providers' abilities to supply quality care.
- AlohaCare should consider conducting provider focus groups to further explore the root causes of dissatisfaction and barriers to provider satisfaction with the health plan. Issues such as dissatisfaction with timeliness of claims payment, health plan communications, and the prior authorization process could be examined by learning of providers' specific experiences and perceptions in order for AlohaCare to select and target its improvement interventions toward the causal factors.

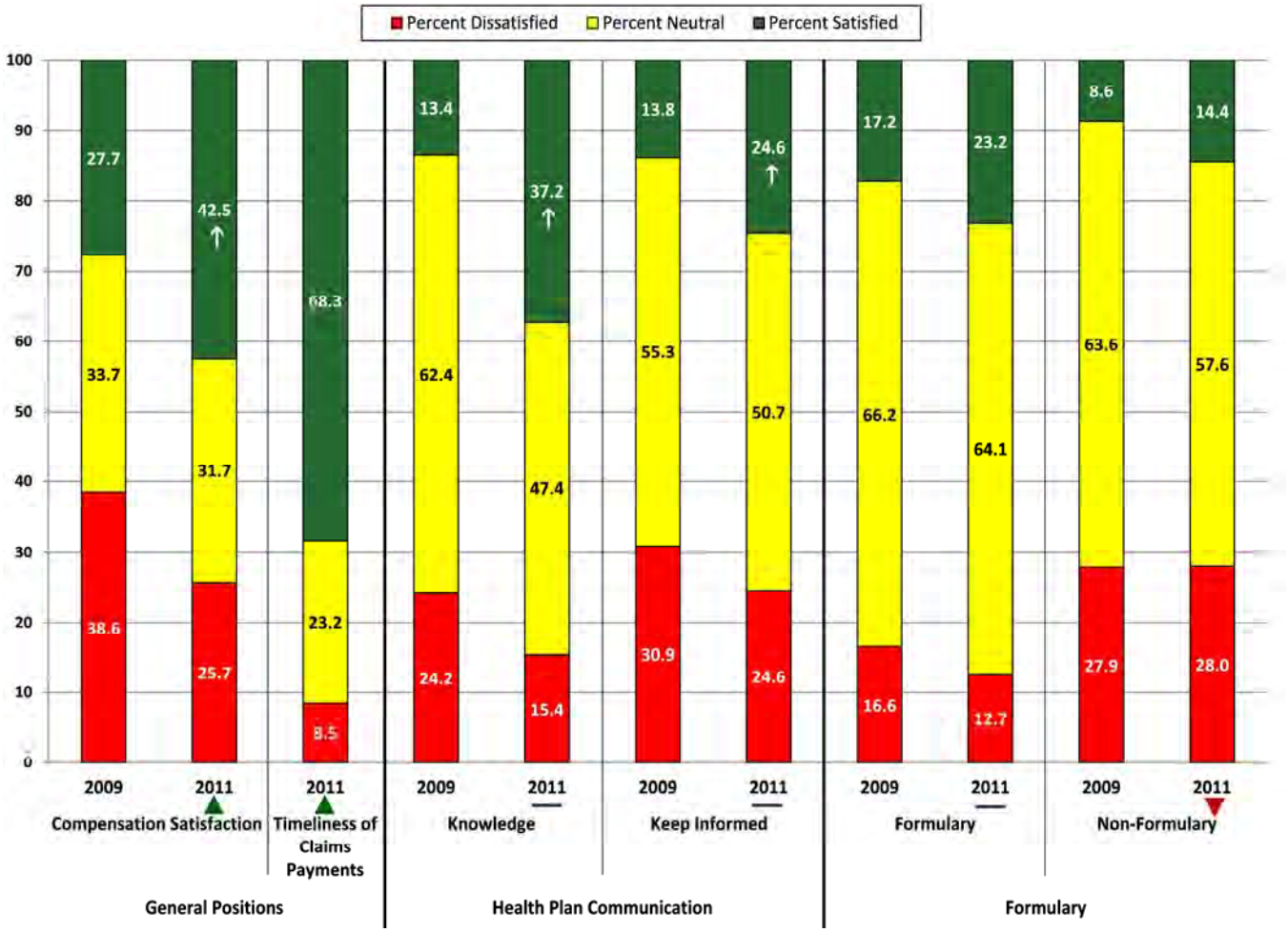
[3-5] Brodsky, Karen L. "Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions." *HealthWorks Consulting, LLC*, 2005.

HMSA

Results and Conclusions

Figure 3-4 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions, health plan communication, and formulary for HMSA.[3-6]

Figure 3-4—HMSA: General Positions, Health Plan Communication, and Formulary



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

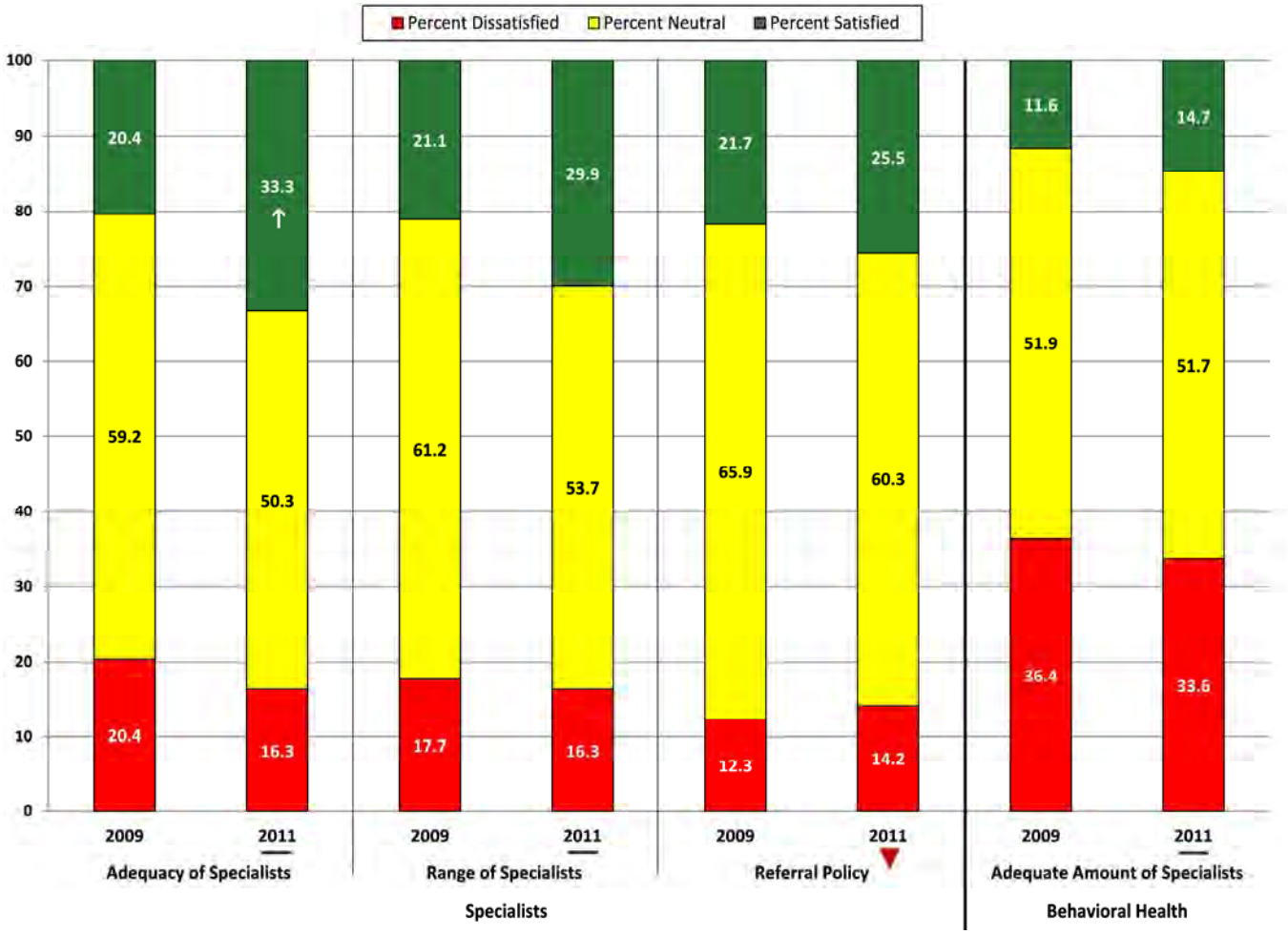
[3-6] 2009 results are not presented for the Timeliness of Claims Payments measure, since this is a new measure for 2011.

- HMSA's 2011 top-box rates for reimbursement/compensation and timeliness of claims payments (42.5 percent and 68.3 percent, respectively) were significantly higher than the aggregate of the other QUEST health plans.
- HMSA's 2011 top-box rates for knowledge and expertise at the health plan and being kept informed about utilization patterns (37.2 percent and 24.6 percent, respectively) were not significantly higher or lower than the aggregate of the other QUEST health plans.
- HMSA's 2011 top-box rate for access to non-formulary drugs (14.4 percent) was significantly lower than the aggregate of the other QUEST health plans. HMSA's top-box rate for adequacy of formulary (23.2 percent) was not significantly higher or lower than the aggregate of the other QUEST health plans.

A comparison of HMSA's 2009 top-box scores to its corresponding 2011 top-box scores revealed that HMSA scored significantly higher in 2011 than in 2009 on three of these measures: reimbursement/compensation, knowledge and expertise at the health plan, and being kept informed about utilization patterns.

Figure 3-5 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of specialists and behavioral health for HMSA.

Figure 3-5—HMSA: Specialists and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*

— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*

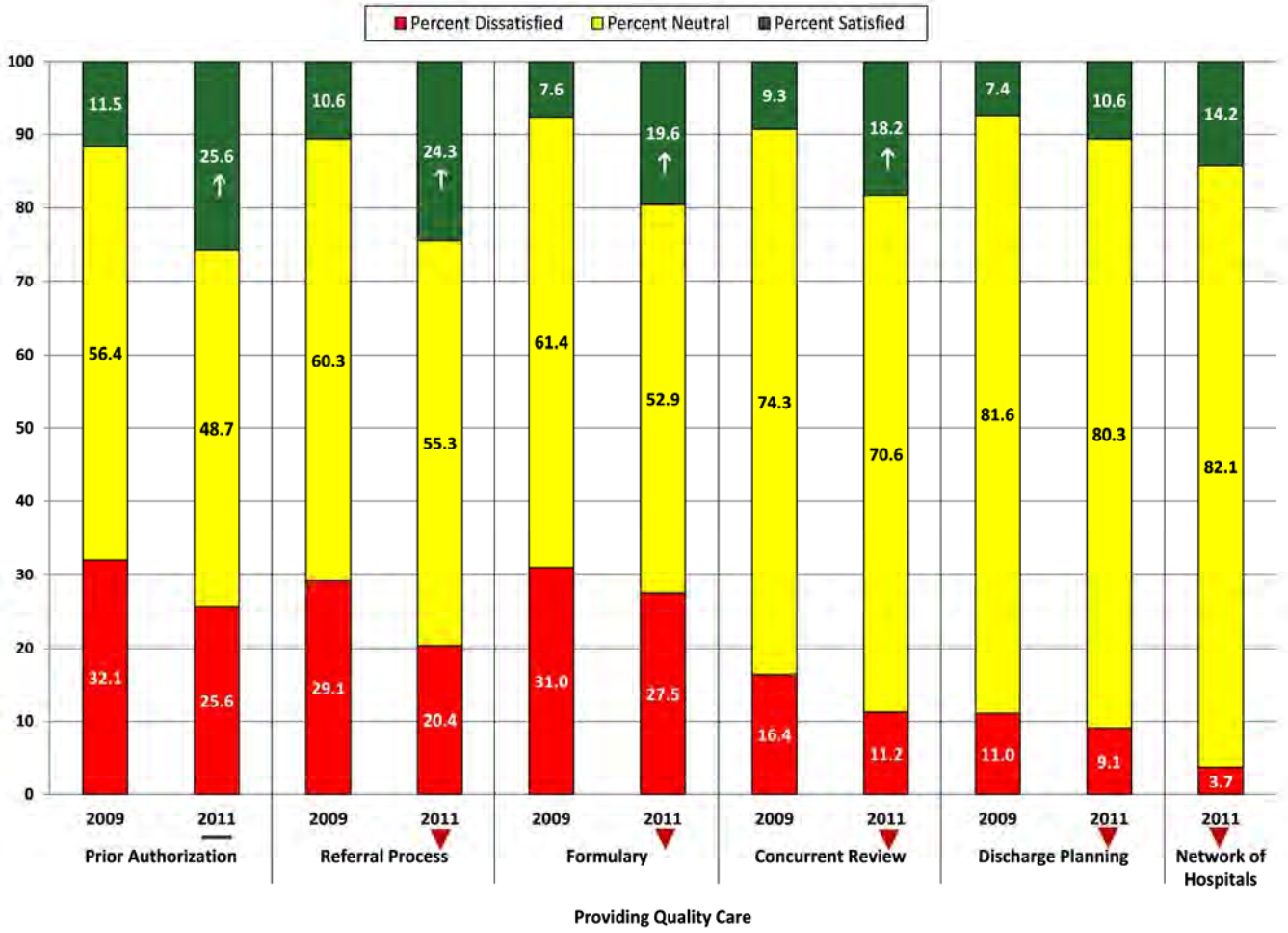
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

- HMSA's 2011 top-box rate referral policy (25.5 percent) was significantly lower than the aggregate of the other QUEST health plans. HMSA's top-box rate for adequacy of specialists and range of specialists (33.3 percent and 29.9 percent, respectively) were not significantly higher or lower than the aggregate of the other QUEST health plans.
- HMSA's top-box rate for adequate amount of behavioral health specialists (14.7 percent) was not significantly higher or lower than the aggregate of the other QUEST health plans.

A comparison of HMSA's 2009 top-box scores to its corresponding 2011 top-box scores revealed that HMSA scored significantly higher in 2011 than in 2009 on the adequacy of specialists measure.

Figure 3-6 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domain of providing quality care for HMSA.[3-7]

Figure 3-6—HMSA: Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

[3-7] 2009 results are not presented for the Network of Hospitals measure, since this is a new measure for 2011.

- HMSA's 2011 top-box rates for referral process, formulary, concurrent review, discharge planning, and network of hospitals measures (24.3 percent, 19.6 percent, 18.2 percent, 10.6 percent, and 14.2 percent, respectively) were significantly lower than the aggregate of the other QUEST health plans. HMSA's top-box rate for prior authorization process (25.6 percent) was not significantly higher or lower than the aggregate of the other QUEST health plans.

A comparison of HMSA's 2009 top-box scores to its corresponding 2011 top-box scores revealed that HMSA scored significantly higher in 2011 than in 2009 on four of these measures: prior authorization, referral policy, formulary, and concurrent review.

Recommendations

The Provider Survey revealed that there are several opportunities for HMSA to improve provider satisfaction. HSAG has provided some potential quality improvement suggestions that the health plan and the MQD may use to increase satisfaction.

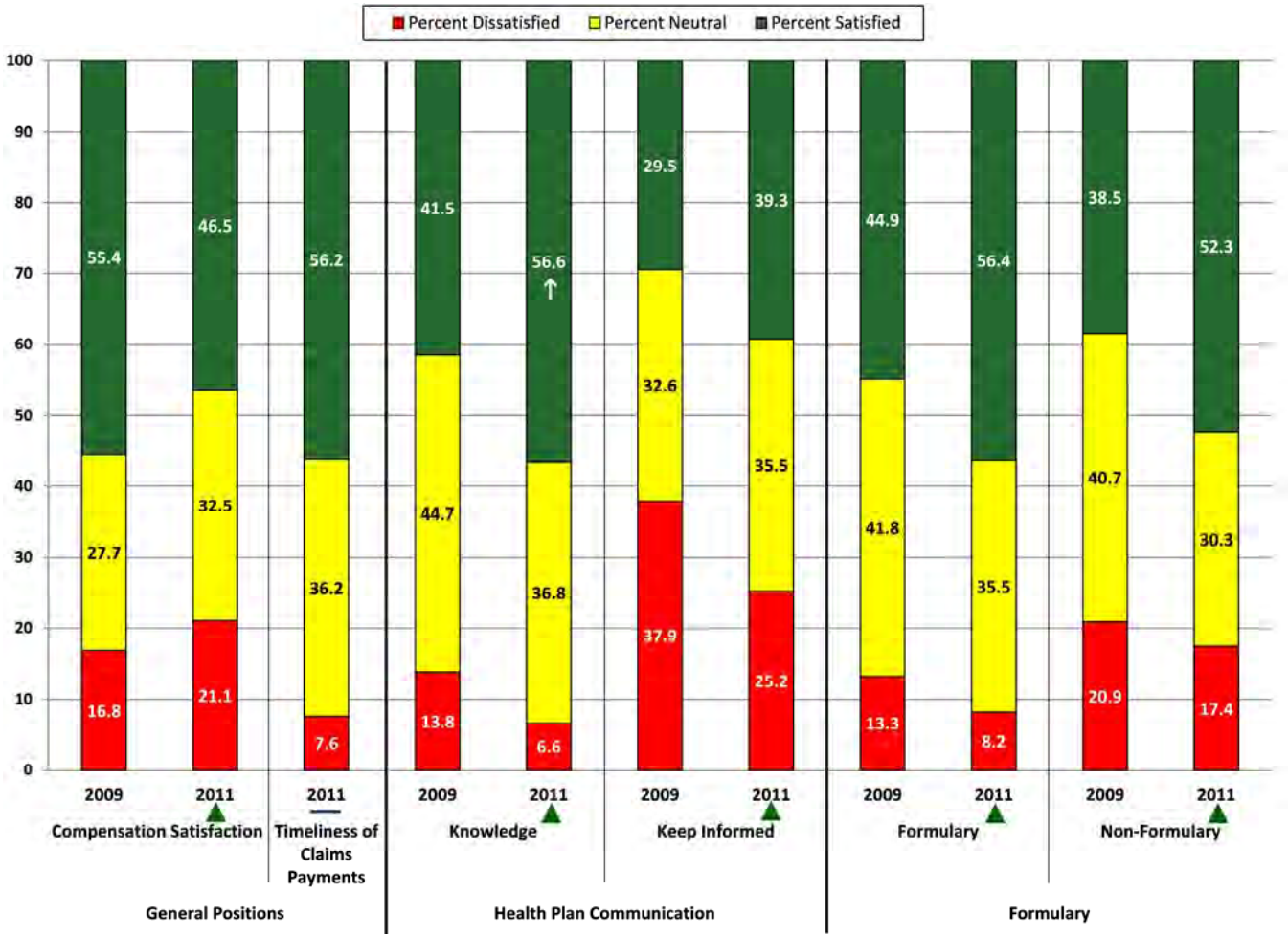
- Opportunities exist based on providers' feedback to ensure that HMSA has an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary. The MQD could review the formulary list periodically to ensure that the list is updated to include essential medicines and drugs that follow standard treatment guidelines. The MQD should consider working with the health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- HMSA is planning to use information technology to automate its authorization and referral processes, and has scheduled "roll-out" of its new provider interface system during 2012. Automation of these processes can help facilitate patient care and allow for efficient communication with providers through an online authorization and referral submission tool that allows providers to submit requests and receive timely responses electronically. HMSA should consider using a small core group of providers as a pilot group for training and testing the new system, and to evaluate success and satisfaction early in the roll-out phase. HMSA could then incorporate any necessary changes to the system or process before a general "go live" date.
- HMSA could conduct an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization are approved. For those specialty categories and medical services that have high approval rates, the HMSA could investigate the possibility of no longer requiring a referral or authorization in order for these processes to have a more positive impact on providers' abilities to supply quality care.
- HMSA should consider conducting provider focus groups to further explore the root causes of dissatisfaction and barriers to providers' satisfaction with the health plan. Issues such as dissatisfaction with referral and prior authorization/concurrent review processes and with discharge planning could be further examined by learning of providers' specific experiences and perceptions in order for HMSA to select and target its improvement interventions toward the causal factors.

Kaiser

Results and Conclusions

Figure 3-7 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions, health plan communication, and formulary for Kaiser.[3-8]

Figure 3-7—Kaiser: General Positions, Health Plan Communication, and Formulary



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

- Kaiser's 2011 top-box rate for reimbursement/compensation (46.5 percent) was significantly higher than the aggregate of the other QUEST health plans. Kaiser's top-box rate for timeliness

[3-8] 2009 results are not presented for the Timeliness of Claims Payments measure, since this is a new measure for 2011.

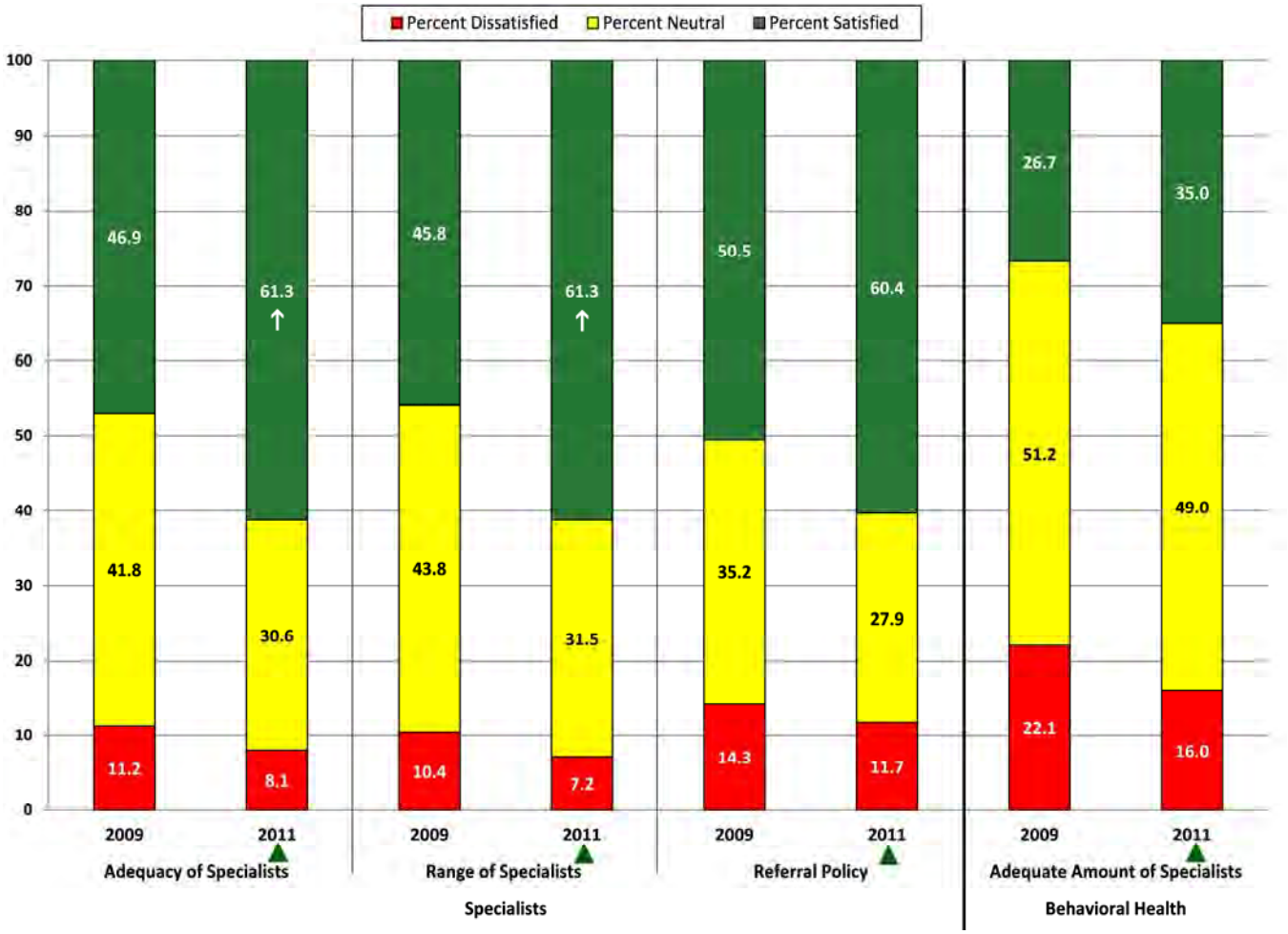
of claims payments (56.2 percent) was not significantly higher or lower than the aggregate of the other QUEST health plans.

- Kaiser's 2011 top-box rates for knowledge and expertise at the health plan and being kept informed about utilization patterns (56.6 percent and 39.3 percent, respectively) were significantly higher than the aggregate of the other QUEST health plans.
- Kaiser's 2011 top-box rates for adequacy of formulary and access to non-formulary drugs (56.4 percent and 52.3 percent, respectively) were significantly higher than the aggregate of the other QUEST health plans.

A comparison of Kaiser's 2009 top-box scores to its corresponding 2011 top-box scores revealed that Kaiser scored significantly higher in 2011 than in 2009 on the measure related to knowledge and expertise at the health plan.

Figure 3-8 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of specialists and behavioral health for Kaiser.

Figure 3-8—Kaiser: Specialists and Behavioral Health



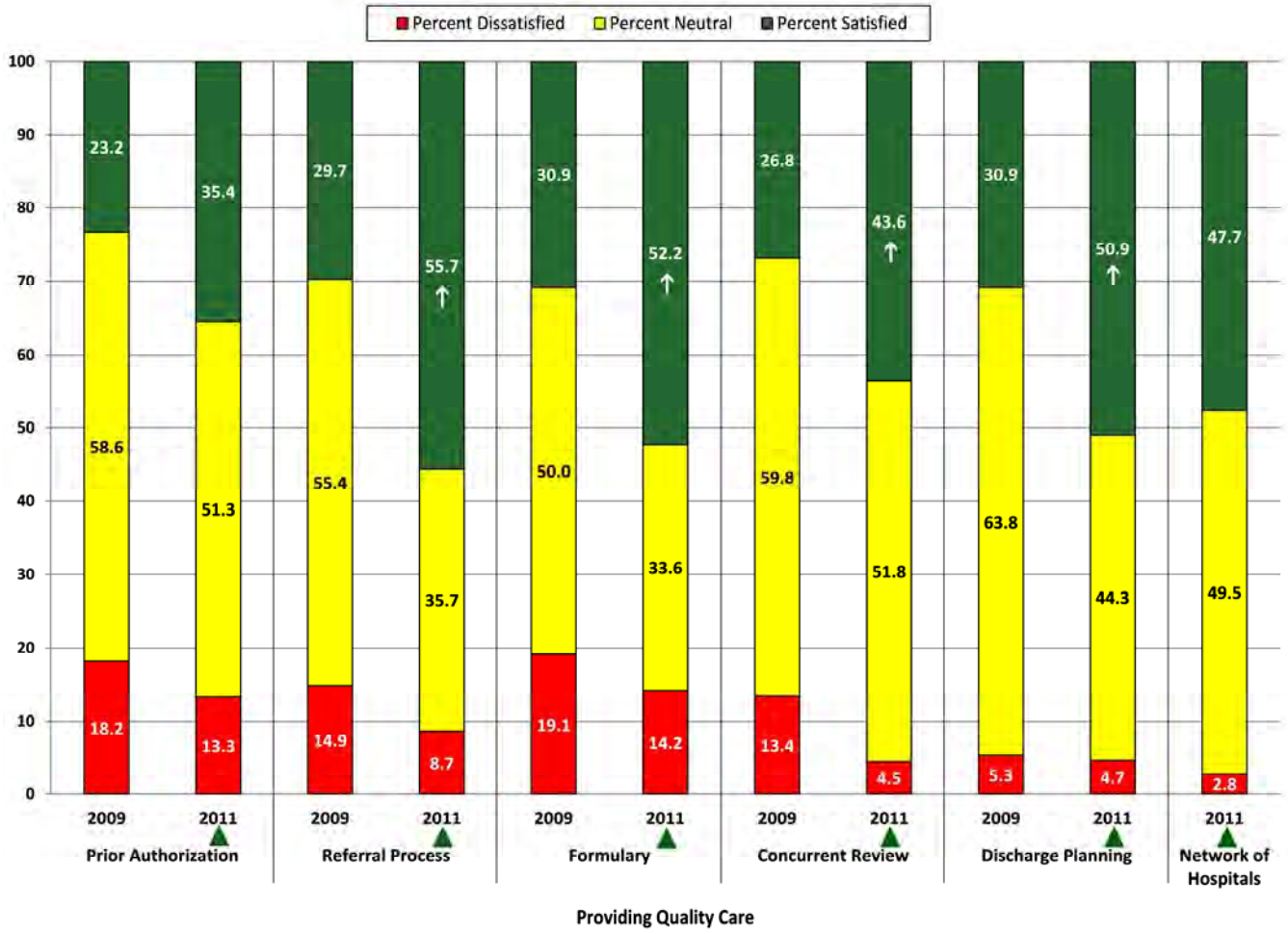
Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

- Kaiser's 2011 top-box rates for adequacy of specialists, range of specialists, and referral policy (61.3 percent, 61.3 percent, and 60.4 percent, respectively) were significantly higher than the aggregate of the other QUEST health plans.
- Kaiser's 2011 top-box rate for adequate amount of behavioral health specialists (35.0 percent) was significantly higher than the aggregate of the other QUEST health plans.

A comparison of Kaiser's 2009 top-box scores to its corresponding 2011 top-box scores revealed that Kaiser scored significantly higher in 2011 than in 2009 on two of these measures: adequacy of specialists and range of specialists.

Figure 3-9 depicts the 2009 and 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domain of providing quality care for Kaiser.[3-9]

Figure 3-9—Kaiser: Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2011 top-box rate is significantly higher than the 2009 top-box rate*
↓ *indicates the 2011 top-box rate is significantly lower than the 2009 top-box rate*

[3-9] 2009 results are not presented for the Network of Hospitals measure, since this is a new measure for 2011.

- Kaiser's 2011 top-box rates for prior authorization process, referral process, formulary, concurrent review, discharge planning, and network of hospitals (35.4 percent, 55.7 percent, 52.2 percent, 43.6 percent, 50.9 percent, and 47.7 percent, respectively) were significantly higher than the aggregate of the other QUEST health plans.

A comparison of Kaiser's 2009 top-box scores to its corresponding 2011 top-box scores revealed that Kaiser scored significantly higher in 2011 than in 2009 on four of these measures: referral process, formulary, concurrent review, and discharge planning.

Recommendations

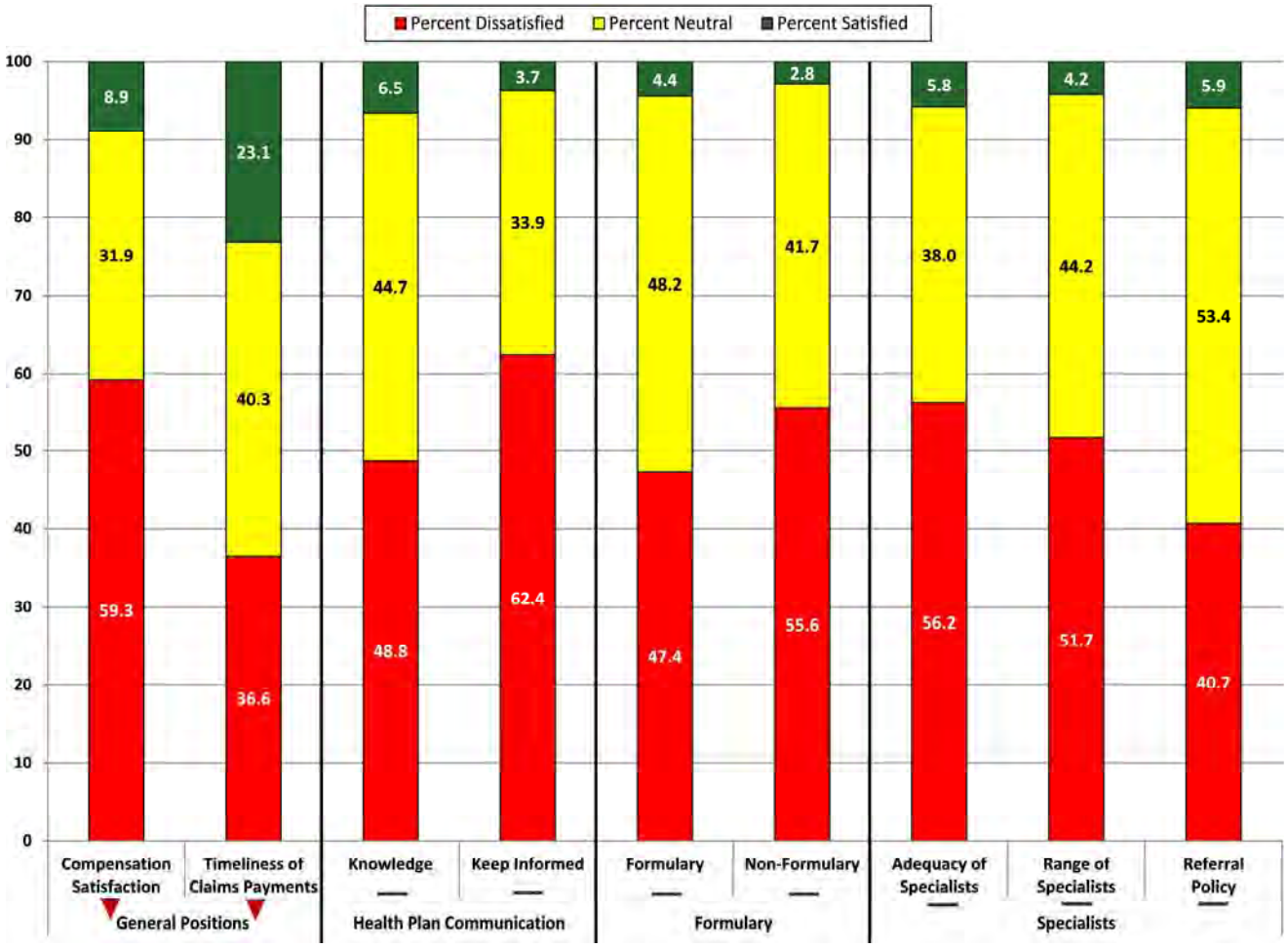
While Kaiser ranked highest of all the QUEST plans in every category of provider satisfaction measured by the survey and showed statistically significant improvement in several domains over the prior survey (2009), the health plan is encouraged to continue its quality improvement efforts in the area of provider satisfaction. Kaiser could select one or two priority areas for improvement and conduct provider focus groups or "round table" discussions to further explore the root causes of dissatisfaction and barriers to satisfaction with the health plan in those areas. Learning more about providers' specific experiences and perceptions would assist Kaiser in selecting and targeting its improvement interventions toward the causal factors.

Evercare

Results and Conclusions

Figure 3-10 depicts the 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions, health plan communication, formulary, and specialists for Evercare.

Figure 3-10—Evercare: General Positions, Health Plan Communication, Formulary, and Specialists



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plan*

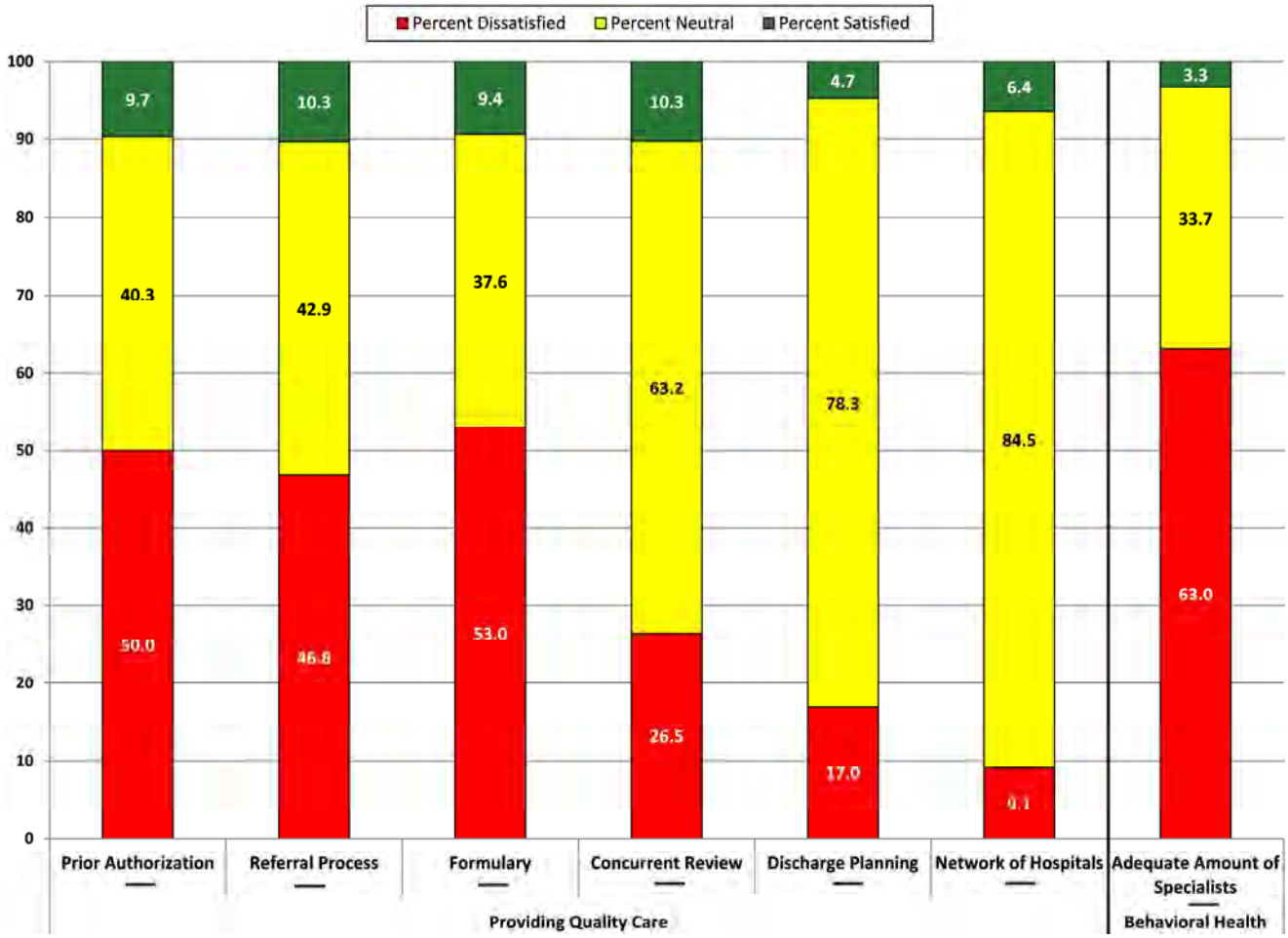
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plan*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plan*

- Evercare's 2011 top-box rates for reimbursement/compensation and timeliness of claims payments (8.9 percent and 23.1 percent, respectively) were significantly lower than the other QExA health plan.
- Evercare's 2011 top-box rates for knowledge and expertise at the health plan and being kept informed about utilization patterns (6.5 percent and 3.7 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Evercare's 2011 top-box rates for adequacy of formulary and access to non-formulary drugs (4.4 percent and 2.8 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Evercare's 2011 top-box rates for adequacy of specialists, range of specialists, and referral policy (5.8 percent, 4.2 percent, and 5.9 percent, respectively) were not significantly higher or lower than the other QExA health plan.

Figure 3-11 depicts the 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of providing quality care and behavioral health for Evercare.

Figure 3-11—Evercare: Providing Quality Care and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plan*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plan*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plan*

- Evercare's 2011 top-box rates for prior authorization process, referral process, formulary, concurrent review, discharge planning, and network of hospitals (9.7 percent, 10.3 percent, 9.4 percent, 10.3 percent, 4.7 percent, and 6.4 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Evercare's 2011 top-box rate for adequate amount of behavioral health specialists (3.3 percent) was not significantly higher or lower than the other QExA health plan.

Recommendations

The Provider Survey revealed that Evercare has several opportunities to improve provider satisfaction. HSAG has provided some potential quality improvement suggestions that Evercare and the MQD may use to increase satisfaction.

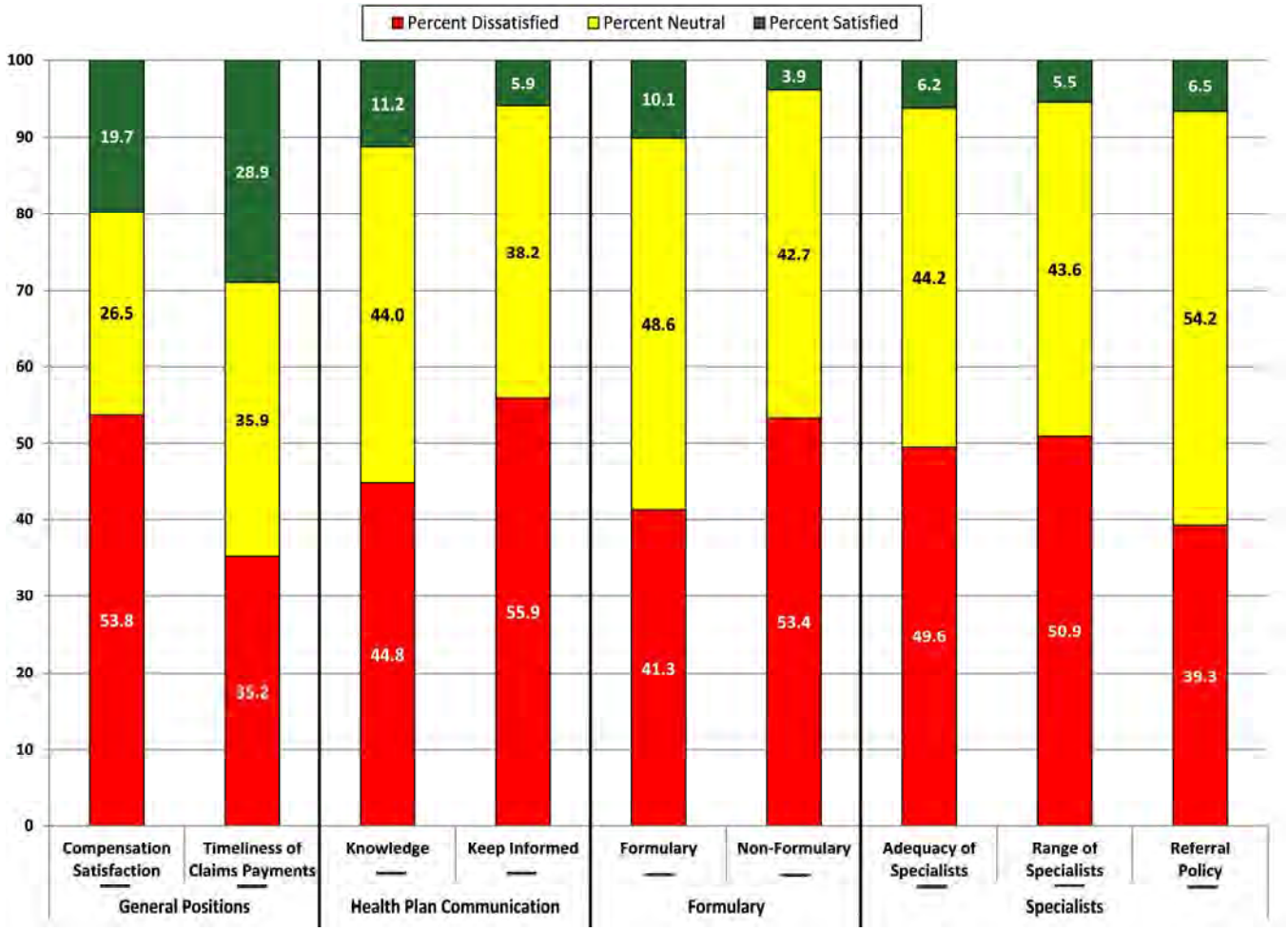
- Providers consistently expressed concerns about the knowledge and expertise of the staff at the health plan. Evercare can provide educational sessions to ensure the staff members are up to date and well informed about information on patient care and services requested by providers. Staff members should be knowledgeable of basic information such as patient benefits, claims and billing, authorization and utilization management procedures, and other processes related to health plan operations that support providers.
- Opportunities exist based on providers' feedback to ensure that the health plan has an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary. The MQD could review the formulary list periodically to ensure that the list is updated to include essential medicines and drugs that follow standard treatment guidelines. The MQD should consider working with the health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- If not already available, Evercare should use information technology to automate its authorization and referral processes. Automation of these processes can help facilitate patient care and allow for efficient communication with providers. An example includes use of an online authorization and referral submission tool that allows providers to submit requests and receive approvals electronically. Automating these processes can also (1) minimize the number of human touches required for patient authorization, referral, and claims processing; (2) reduce the time required for providers to receive an authorization; (3) improve the timeliness of patient care; and (4) improve claims processing.
- Evercare should consider conducting an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization are approved. For those specialty categories and medical services that have high approval rates, Evercare could investigate the possibility of no longer requiring a referral or authorization in order for these processes to have a more positive impact on providers' abilities to supply quality care.
- Evercare should consider conducting provider focus groups to further explore the root causes of dissatisfaction and barriers to provider satisfaction with the health plan. Issues such as dissatisfaction with timeliness of claims payment, health plan communications, and the network of hospitals and specialists could be examined by learning of providers' specific experiences and perceptions in order for Evercare to select and target its improvement interventions toward the causal factors.

Ohana

Results and Conclusions

Figure 3-12 depicts the 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions, health plan communication, formulary, and specialists for Ohana.

Figure 3-12—Ohana: General Positions, Health Plan Communication, Formulary, and Specialists



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plan*

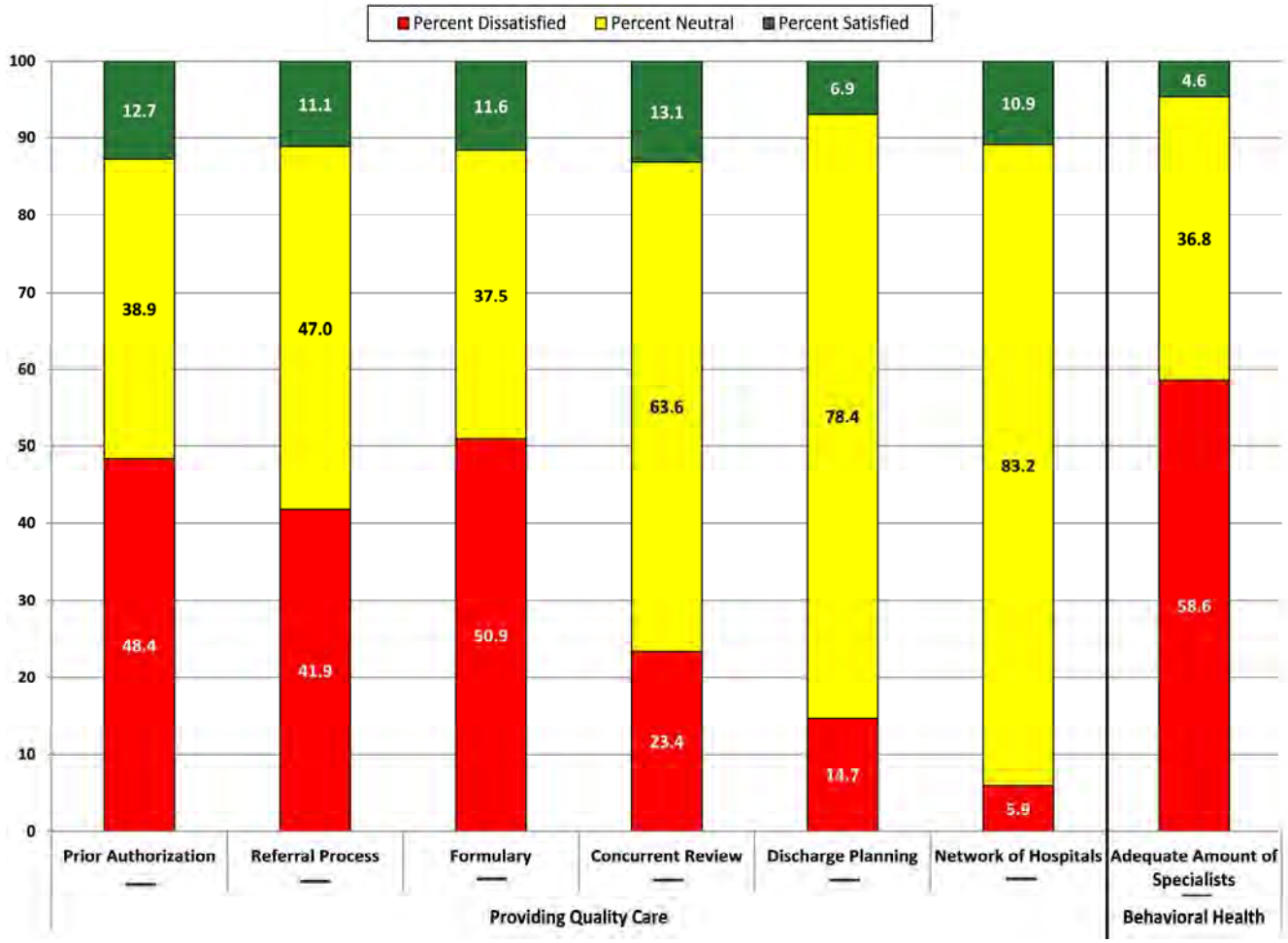
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plan*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plan*

- Ohana's 2011 top-box rates for reimbursement/compensation and timeliness of claims payments (19.7 percent and 28.9 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Ohana's 2011 top-box rates for knowledge and expertise at the health plan and being kept informed about utilization patterns (11.2 percent and 5.9 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Ohana's 2011 top-box rates for adequacy of formulary and access to non-formulary drugs (10.1 percent and 3.9 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Ohana's 2011 top-box rates for adequacy of specialists, range of specialists, and referral policy (6.2 percent, 5.5 percent, and 6.5 percent, respectively) were not significantly higher or lower than the other QExA health plan.

Figure 3-13 depicts the 2011 response category proportions (i.e., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of providing quality care and behavioral health for Ohana.

Figure 3-13—Ohana: Providing Quality Care and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plan*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plan*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plan*

- Ohana's 2011 top-box rates for prior authorization process, referral process, formulary, concurrent review, discharge planning, and network of hospitals (12.7 percent, 11.1 percent, 11.6 percent, 13.1 percent, 6.9 percent, and 10.9 percent, respectively) were not significantly higher or lower than the other QExA health plan.
- Ohana's 2011 top-box rate for adequate amount of behavioral health specialists (4.6 percent) was not significantly higher or lower than the other QExA health plan.

Recommendations

The Provider Survey revealed that Ohana has several opportunities to improve provider satisfaction. HSAG has provided some potential quality improvement suggestions that Ohana and the MQD may use to increase satisfaction.

- Providers consistently expressed concerns about the knowledge and expertise of the staff at the health plan. Ohana can provide educational sessions to ensure the staff members are up to date and well informed about information on patient care and services requested by providers. Staff members should be knowledgeable of basic information such as patient benefits, claims and billing, authorization and utilization management procedures, and other processes related to health plan operations that support providers.
- Opportunities exist based on providers' feedback to ensure that the health plan has an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary. The MQD could review the formulary list periodically to ensure that the list is updated to include essential medicines and drugs that follow standard treatment guidelines. The MQD should consider working with the health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- If not already available, Ohana should use information technology to automate its authorization and referral processes. Automation of these processes can help facilitate patient care and allow for efficient communication with providers. An example includes use of an online authorization and referral submission tool that allows providers to submit requests and receive approvals electronically. Automating these processes can also (1) minimize the number of human touches required for patient authorization, referral, and claims processing; (2) reduce the time required for providers to receive an authorization; (3) improve the timeliness of patient care; and (4) improve claims processing.
- Ohana should consider conducting an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization are approved. For those specialty categories and medical services that have high approval rates, Ohana could investigate the possibility of no longer requiring a referral or authorization in order for these processes to have a more positive impact on providers' abilities to supply quality care.
- Ohana should consider conducting provider focus groups to further explore the root causes of dissatisfaction and barriers to provider satisfaction with the health plan. Issues such as dissatisfaction with timeliness of claims payment, health plan communications, and the network of hospitals and specialists could be examined by learning of providers' specific experiences and perceptions in order for Ohana to select and target its improvement interventions toward the causal factors.

Overall Conclusions and Recommendations for Each Health Plan

The following overall conclusions and additional recommendations are provided by HSAG for each QUEST and QExA health plan, taking into account the plans' performance across all EQR activities performed in 2011, as well as effectiveness of improvement actions reported by the health plans as a result of last year's EQR activities (as detailed in Section 5 of this report).

AlohaCare

AlohaCare's 2011 EQR activity results demonstrate that the plan ranks overall as the poorest performing QUEST health plan. While the health plan documented numerous quality improvement initiatives it has implemented over the past two years, there was little or no improvement and several declines in most measures of quality outcomes, access, and satisfaction (HEDIS measures, PIPs, CAHPS, provider survey). AlohaCare had higher emergency department visits and lower outpatient visit rates per 1,000 member months than the other two QUEST plans, and nearly all its measures of children's prevention, women's health screenings, and care for chronic conditions were below the national HEDIS 2010 Medicaid 25th percentile, and well below the MQD's Quality Strategy targets. Member and provider indicators of satisfaction also showed overall lower levels of satisfaction with AlohaCare and its services than with the other QUEST plans, and only one indicator showed statistically significant improvement from the previous provider survey (2009). These results suggest that AlohaCare needs to focus on improving its access to appropriate, quality care and services. The results also suggest that AlohaCare's quality improvement process is not having the desired effect. AlohaCare's process should include analyzing barriers, selecting appropriate interventions, and ensuring regular evaluation of the effects of its efforts. HSAG strongly suggests that the health plan focus on the following quality improvement strategies:

Conduct Causal Analyses of Barriers

Analyses of barriers to improvement are an effective means of identifying whether quality improvement (QI) interventions are meeting the needs of the targeted population(s) and appropriately addressing gaps in patient care or service. As an example, AlohaCare could conduct a causal analysis of its Patient-Centered Health Care Homes (PCHCHs) to determine if the care management of targeted populations has indeed improved, and if so, is this improvement a result of the newly implemented PCHCH model or a result of outside factors. Further, if the results of this analysis reveal that the PCHCH model has not been effective in improving patients' access to care, coordination of care, experience(s) with the health plan, and reducing the costs of care, AlohaCare should perform further "drill-down" analysis of the populations targeted through this intervention. For example, barriers to improving the overall delivery of care could be correlated to low performance in a particular domain, such as the patients' experiences with receiving care in a timely manner. To determine this, AlohaCare could use the key drivers of satisfaction identified in the CAHPS report and leverage these results with the additional CAHPS data available in the crosstabulations to identify if a specific age group, race/ethnicity, or gender is reporting higher levels of dissatisfaction on the domain of *Getting Care Quickly*. With this information, AlohaCare would be able to identify how the PCHCH model could be redesigned to meet the needs of a specific subgroup of the targeted population prior to expanding this model to its entire health care

system. Further, AlohaCare could use existing patient-centered medical home programs that have proven to be successful in strengthening provider-patient interaction and improving coordination of care as a source of information on how to model their PCHCHs to improve the likelihood of achieving the desired results.

Other potential areas for barrier analyses should also be considered, based on the results of measures of care and satisfaction, and HSAG suggests member and provider input, perhaps via focus groups, to better understand the perceptions and experiences of the AlohaCare customers. Based on findings in this report, other areas that might be considered for further exploration are:

- Utilization management and authorization/referral practices and patterns
- After-hours service availability, other than emergency room
- Accessibility of outpatient services (e.g., transportation and geo-access issues)
- Member educational and informational materials (e.g., understandability)

Perform Interim Evaluations

Implementing a process for conducting interim evaluations of QI activities will allow AlohaCare to continually assess the efficacy of its interventions, and identify which interventions are most successful and which have not been effective in achieving positive results. As an example, AlohaCare could perform an interim evaluation of its existing Quality Improvement Incentive Programs (QIIPs) for participating providers and its Member Incentive Program to determine if the incentive programs have resulted in improved care among its targeted population. Routine assessment of these incentive programs would allow AlohaCare to identify if program resources are adequate enough to sustain these QI efforts. This could be accomplished by performing an analysis between those providers who participated in the QIIP, how many providers were successful in achieving improvements, and to what degree it affected overall rates (i.e., percentage of increase or decrease). Based on the results of these evaluations, AlohaCare will be able to determine if its interventions focused on incentivizing its providers and/or members are an efficient use of the health plan's resources, if these programs should be modified, or new activities should be implemented to reach the desired results.

HMSA

An overall review of HMSA's findings from each of the 2011 EQR activities reveal that HMSA could focus its QI efforts on performing analyses of potential improvement barriers and conducting interim reviews of its interventions to determine if the health plan is accurately targeting the source of the problem and achieving the desired results. HMSA implemented a large number of improvement activities over the past two years aimed at improving various rates and other measures of quality, outcomes, and satisfaction. While HMSA's EQR results demonstrated areas of statistically significant improvement on several HEDIS indicators, both PIPs, and several measures of provider satisfaction, room for improvement remains. Despite these areas of improvement, HMSA did not reach the MQD's Quality Strategy target on any of the measures of children's prevention, women's health screening, or care for chronic conditions. Member satisfaction results were not statistically different from the previous CAHPS Child survey. Overall, HMSA had moderate performance compared to the other two QUEST plans. The following are general

recommendations that HMSA should view as potential activities that can be incorporated into a comprehensive QI plan to increase provider and member satisfaction and to improve quality of the health plan's care and services.

Identify and Address Potential Improvement Barriers

QI interventions that are not targeting the source of the problem and appropriately addressing gaps in patient care can be a barrier to improvement. In order to determine if barriers to improvement exist, the root cause of low performance must first be identified. This can be accomplished through analyses of areas of continued low performance. For instance, HMSA could conduct a root cause analysis of study indicators that have continually been identified as low performing, such as CAHPS scores on *Getting Needed Care* and *Getting Care Quickly*. This type of analysis would allow HMSA to identify the specific population(s) that should be targeted for QI intervention. As an example, HMSA could use the data provided in CAHPS crosstabulations along with key drivers of satisfaction identified for each of these priority areas in the CAHPS reports to determine if a particular age group, gender, or race/ethnicity is reporting higher levels of dissatisfaction. QI interventions could then be designed and implemented based on the needs of this specific population. A root cause analysis of this type could also be conducted on areas of low performance on HEDIS indicators, such as comprehensive diabetes care measures and cholesterol screening for patients with cardiovascular conditions.

Perform Interim Evaluations of QI Interventions

In order to determine if QI interventions are effectively addressing gaps in the delivery of care, interim evaluations of these activities should be employed. Interim evaluations are beneficial not only in helping health plans identify if current interventions are successful, but also if QI activities should be modified or new ones implemented to achieve the desired results. For example, it was identified that while rates for *CIS* and *CDC* indicators had improved from the previous year, rates on these measures still remain low. Therefore, HMSA could perform an interim review of its current QI activities aimed at improving *CIS* and *CDC* rates to determine which interventions have been most successful and which have not been as effective an anticipated. An interim evaluation could include administering a short survey to members asking them to identify which, if any, of the *CIS* and *CDC* improvement activities (e.g., reminder programs or educational materials) had an impact on their decision to visit a physician for these services. In addition, periodic review of interventions that have been implemented to improve the delivery of care will enable HMSA to determine the effectiveness of such interventions. HMSA could determine, for example, whether linking a provider payment incentive to completion of EPSDT forms contributed to improved rates on its *BMI* measure. If it is determined that these programs and services are not effective, HMSA could use this information to reassess and determine whether the intervention should be modified or if resources should be allocated to implement new program or services that might be more beneficial.

Kaiser

An overall review of Kaiser's findings from each of the EQR activities reveals that Kaiser was the top performing QUEST plan on nearly all measures of quality, outcome, and satisfaction. While Kaiser did not document in detail its quality improvement approaches over the past two years, the health plan attained performance results that frequently met or exceeded the MQD's Quality Strategy targets. In addition, several of the already high results in 2010 achieved statistically significant increases in 2011. To continue to improve in the remaining lower areas of performance, Kaiser could focus QI initiatives on conducting further analyses of those indicators in order to ensure that interventions are targeting the root cause(s) of these problem areas. The following are general recommendations that Kaiser should view as potential activities that can be incorporated into a comprehensive QI plan to improve member and provider satisfaction and quality of care and service.

Conduct Further Analyses of Low Performance Areas

Kaiser could perform further analyses of continued low performance study indicators, such as comprehensive diabetes care rates for HbA1c control. These types of analyses could be focused on identifying the root cause of low performance on these HEDIS measures. For example, an analysis of the geographic locations of the health plan's diabetes patients would allow Kaiser to identify if QI interventions would be more beneficial if implemented in certain geographic regions where the majority of this patient population resides. Further, this type of analysis could assist Kaiser in identifying if gaps in diabetes patient care are more prevalent in a subset of this population. Based on the results of these analyses, Kaiser could determine if current QI activities are accurately targeting the population or subpopulation of patients most in need. In addition, Kaiser could use these results to decide if interventions should be re-focused or new ones implemented based on their understanding of the population.

A similar form of analysis could be conducted on specific CAHPS study indicators that tend to be areas of lower performance, such as *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. CAHPS findings show that patient satisfaction on these measures remains low and continue to be priority improvement areas for Kaiser. To address challenges in improving CAHPS scores on these measures, Kaiser could perform a "drill-down" analysis of improvement barriers. This type of analysis could help Kaiser not only identify specific "problem areas," but also determine if a subset of the population is disproportionately contributing to overall low performance. As an example, Kaiser could use the supplemental CAHPS data provided in the crosstabulations and leverage this information with the key drivers of satisfaction identified for each priority in the CAHPS report to determine if a particular demographic of the population (e.g., age group, race/ethnicity, or gender) is reporting higher levels of dissatisfaction on these CAHPS measures. With this information, Kaiser would be able to create and implement a more precise, concentrated QI intervention to address specific gaps in member satisfaction.

Evercare

An overall review of Evercare's findings from each of the EQR activities reveal that Evercare's performance is not significantly different from the other QExA plan, and that numerous opportunities for improvement exist. Performance on HEDIS measures of care quality and outcome show that Evercare exceeded the MQD's Quality Strategy target on one HEDIS indicator, for the *CDC* measure (*LDL-C Screening*), however, did not meet the targets for any other HEDIS measures in the domains of children's prevention, women's health screening, and care for chronic conditions. Evercare's high ED visit rate and high outpatient visit rate signal an opportunity for exploration of these patterns of utilization to determine appropriateness of the care, and to analyze for patient subsets or health plan processes that might be driving these higher rates. Member and provider satisfaction surveys also show room for significant improvement. Evercare implemented numerous improvement strategies since the previous year's EQR activities, and is encouraged to focus future QI activities on performing interim evaluations of its current interventions and performing "drill-down" analyses of potential improvement outcome barriers. Opportunities exist to improve the overall quality of care it provides across various domains, and to improve member and provider satisfaction. The following are general recommendations that Evercare can incorporate into a comprehensive QI plan.

Perform Interim Evaluations

Interim evaluations of current QI activities will allow Evercare to determine if interventions have been effective in achieving the desired results. Interim evaluations could include surveying members and/or service care coordinators to identify whether newly implemented programs (e.g., a disease management program) and services are being utilizing and meeting members' needs. Additionally, Evercare could implement a process for obtaining service coordinators' feedback on QI interventions. For example, "round table" sessions could be incorporated into service coordinators' quarterly meetings or training workshops. This will provide the coordinators an environment in which they can provide feedback on current interventions and share their ideas on new programs or services that could be implemented to improve the delivery of care and reduce barriers preventing the delivery of appropriate care.

In addition to interim evaluations, Evercare could look at strategies currently being employed by comparable organizations with patient populations that have similar needs (e.g., long-term health care needs) to identify best practices that could be incorporated into their current interventions and further ensure the success of their QI efforts.

Identify and Address Barriers for Improvement

Evercare should employ additional methods for identifying barriers to improvement in outcomes in order to ensure that QI interventions are targeted to meet the needs of its members and address gaps in patient care. For example, Evercare could conduct a "drill-down" analysis of ED and outpatient visit utilization to determine if any subgroup within the population has a disproportionately higher rate of ED and outpatient visits and/or the top diagnoses that account for these visits. This will assist Evercare in identifying those subpopulations that could be targeted for intervention and allow for more precise, concentrated quality improvement interventions. In addition to population analysis related to high rates of visits, Evercare may want to look at its internal processes and policies

regarding utilization management, authorizations for referrals, and expectations for PCPs regarding management and coordination of member care and services. To address challenges in improving patient satisfaction, Evercare should focus on identifying opportunities for improvement in specific problem areas. A "drill-down" analysis of patient satisfaction would assist Evercare not only in identifying individual problem areas, but also the subset of populations that would most likely benefit from QI activities. As an example, Evercare could use the key drivers of satisfaction identified in the CAHPS report and leverage these results with the supplemental CAHPS data available in the crosstabulations to identify if a specific age group, race/ethnicity, or gender is reporting high levels of dissatisfaction in a particular domain (e.g., getting needed care). With this information, Evercare would be able to design and implement QI interventions customized to meet the needs of a specific subgroup of patients on a particular domain.

Ohana

Ohana's findings from each of the EQR activities reveal that the health plan's performance is not significantly different from the other QExA plan, and that numerous opportunities for improvement exist. Performance on HEDIS measures of quality and outcome show that Ohana did not meet the MQD Quality Strategy targets for any other HEDIS measure in the domains of children's prevention, women's health screening, and care for chronic conditions. Ohana's high ED visit rate and high outpatient visit rate signal an opportunity for exploration of these patterns of utilization to determine appropriateness of the care, and to analyze for patient subsets that might be driving these higher rates. Member and provider satisfaction surveys also show room for improvement. Ohana implemented numerous improvement strategies since the previous year's EQR activities, and is encouraged to focus future QI activities on performing interim evaluations of QI strategies and analyses of improvement barriers to assist the health plan in improving care across various indicators. The following are general recommendations that Ohana should view as potential activities that can be incorporated into a comprehensive QI plan.

Conduct Routine Evaluation of QI Strategies

Routine reviews of health plan processes are an effective means for determining if QI strategies aimed at improving these systems are adequately addressing problem areas and achieving the desired results. As an example, compliance monitoring reviews identified that opportunities for improvement exist within the area of coverage and authorization of services for Ohana. To address this, Ohana could perform an interim review of the corrective actions it has implemented to address problem areas, such as the processes for managing pharmacy requests. An interim evaluation of these QI activities, as well as the overall processes for handling pharmacy authorization services would allow Ohana to determine if interventions have been effective in correcting the deficiencies identified and furthermore, if they have led to increased efficiency within the system. In addition, Ohana may want to determine whether its P4P incentive for practitioners to follow diabetes practice guidelines is having the intended effect on the CDC measure and care received. If it is determined that interventions have not been effective, Ohana would be able to use the information gathered through these interim reviews to determine how processes could be modified to achieve the desired results and improve its delivery of services.

Analyses of Improvement Barriers

Continued areas of low performance at times can often be the result of specific improvement barriers. In order to address repeated low performance on indicators, such as HEDIS scores for chronic care measures, Ohana could focus on conducting data mining activities. These types of analyses could assist Ohana in identifying potential barriers for improvement among a subset of the patient population and for specific chronic conditions. For example, Ohana could perform an island-level analysis of diabetes patients to identify if patients in a certain geographic region have disproportionately lower scores compared to neighboring islands. In addition, Ohana could conduct a focus group study of these patients to assist them in further identifying the specific problem areas and gain a better understanding of how to better meet their needs. With the results of these analyses, Ohana could design and implement a more precise, targeted QI intervention concentrated on addressing gaps in patient care among this population. Further, if the targeted intervention proves to be successful, Ohana could replicate this intervention for the larger health plan population.

Introduction

This section compares plan-specific EQR activity results across the five health plans, and provides comparisons to statewide scores or to national benchmarks, if available (for HEDIS measures and CAHPS).

Health Plan Comparison

Compliance Monitoring Review

The following table provides information that can be used to compare all five Hawaii Medicaid managed care health plans' performance on the five compliance standards reviewed in 2011. For further comparison, the statewide scores for performance on each of the standards and a statewide compliance score overall are also provided.

Table 4-1—Standards and Compliance Scores Comparison

Standard #	Standard Name	AlohaCare QUEST	HMSA QUEST	Kaiser QUEST	Evercare QExA	Ohana QExA	Statewide Score
I	Delegation	**77**	**100**	**NA***	**91**	**100**	**92**
II	Member Information	**94**	**92**	**95**	**91**	**98**	**94**
III	Grievance System	**72**	**76**	**62**	**79**	**95**	**77**
IV	Provider Selection	**100**	**100**	**100**	**100**	**100**	**100**
V	Credentialing	**96**	**98**	**100****	**25**	**93**	**83**
	Total Compliance Score:	**89**	**92**	**89**	**64**	**96**	**86**

*Kaiser was not reviewed for this standard, as it did not delegate any managed care functions for its Medicaid program.
**Kaiser was "deemed" compliant for credentialing, as it had attained 100 percent compliance in its NCQA accreditation review.

Across all five health plans, performance was strongest in the areas of member information and provider selection, with statewide scores of 94 and 100 percent respectively.

Although results were somewhat mixed for other standards, there was a 92 percent statewide score and strong performance by three of four plans reviewed for the delegation standard. Four of five plans also scored above 90 percent in the area of credentialing. The two health plans with weakest performance in these two areas were AlohaCare (in delegation) and Evercare (in credentialing).

The grievance system standard had the lowest statewide score, at 77 percent, with four of the five plans performing below 80 percent compliance in that area. This is a targeted area for performance improvement for the MQD and the health plans.

Ohana demonstrated the highest total compliance score, at 96 percent, and was the only health plan to achieve scores greater than 90 percent in all five of the areas reviewed. HMSA also had a high overall compliance score, at 92 percent. While Evercare had the lowest overall score, at 64 percent, this was a function of a single weak area of performance—credentialing, at 25 percent. For all other standards, Evercare scored at or only slightly below the statewide score.

Validation of Performance Measures—HEDIS Compliance Audits

HEDIS Compliance Audits—QUEST Health Plans

Table 4-2 compares each QUEST health plan's compliance with the IS standard reviewed in a HEDIS compliance audit. As demonstrated below, all of the QUEST health plans were *Fully Compliant* with the IS standards that were applicable to the measures under the scope of the audit. The health plans were not required to report any of the HEDIS call center measures; therefore, IS 6.0 was *Not Applicable*.

Table 4-2—Validation of Performance Measures Comparison—QUEST HEDIS Compliance Audit

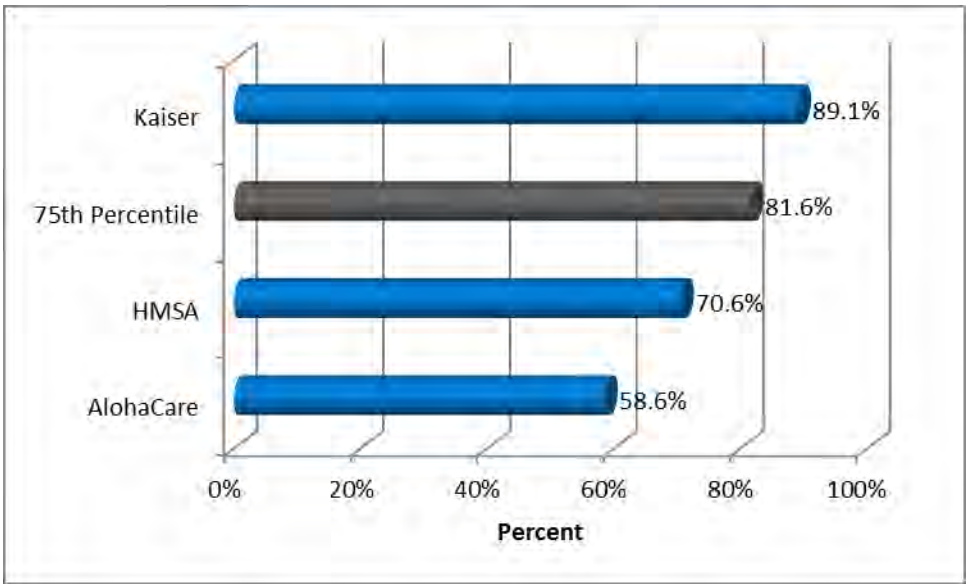
QUEST Health Plan	Information Systems						
	IS 1.0—Medical Data	*IS 2.0—Enrollment Data*	*IS 3.0—Provider Data*	*IS 4.0—Medical Record Data*	*IS 5.0—Supplemental Data*	*IS 6.0—Call Center*	*IS 7.0—Data Integration*
AlohaCare	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***
HMSA	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***
Kaiser	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

QUEST HEDIS Performance Measures

The graphs below display the performance measure results for the QUEST health plans' audited HEDIS 2011 measures compared to the MQD Quality Strategy targets for each measure. For most measures the MQD Quality Strategy target is the national HEDIS Medicaid 75th percentile. For those measures for which a lower rate indicates better performance (i.e., *HbA1c Testing—Poor Control, Ambulatory Care—ED Visits)* the national HEDIS 2010 Medicaid 25th percentile was used as the MQD Quality Strategy target.

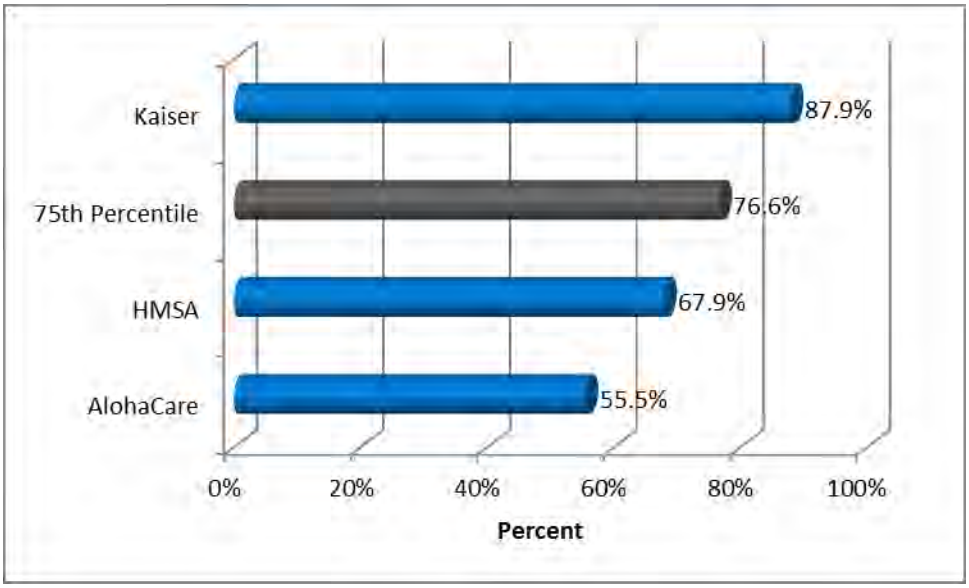
CHILDREN'S PREVENTION MEASURES

CHILDHOOD IMMUNIZATION STATUS (CIS)—COMBO 2



For *CIS—Combo 2,* Kaiser was the top-performing QUEST health plan and AlohaCare was the lowest performing of the three QUEST health plans. Kaiser exceeded the MQD Quality Strategy by 7.5 percentage points and AlohaCare's rate by 30.5 percentage points. HMSA performed 11 percentage points below the MQD Quality Strategy target but did perform better than AlohaCare by 12 percentage points.

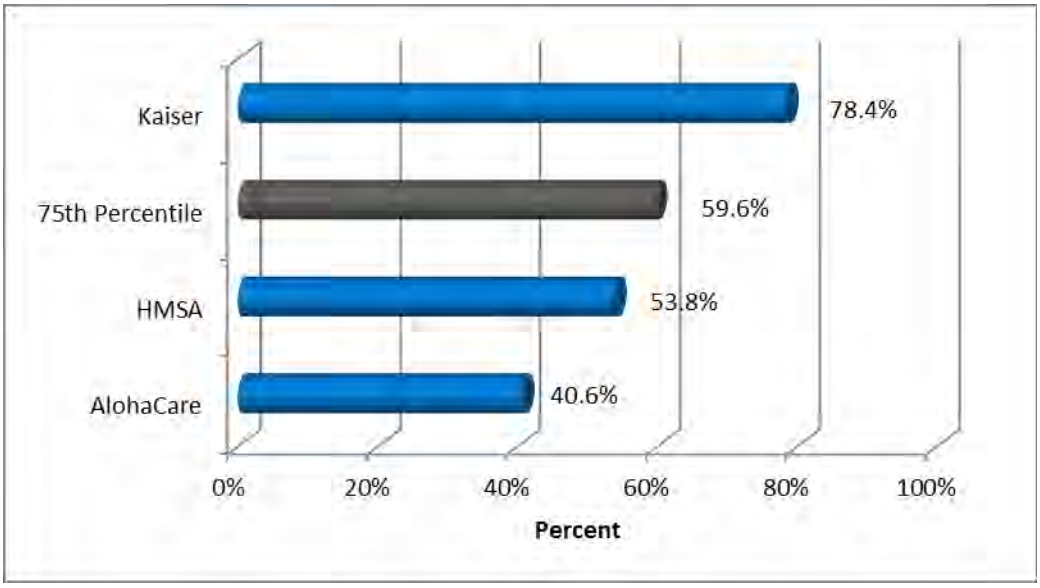
CHILDHOOD IMMUNIZATION STATUS (CIS)—COMBO 3



Kaiser was also the top-performing QUEST health plan for *CIS—Combo 3*. Kaiser exceeded the MQD Quality Strategy target of 76.6 percent by 11.3 percentage points and was 32.4 percentage points above AlohaCare, the lowest-performing QUEST health plan. HMSA performed 8.7 percentage points below the MQD Quality Strategy target but did perform better than AlohaCare by 12.4 percentage points.

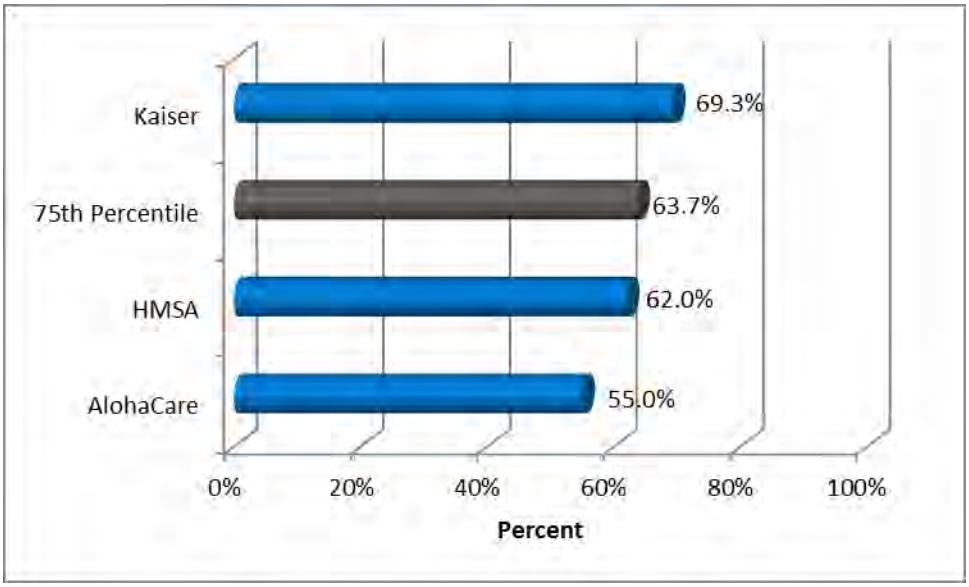
WOMEN'S HEALTH MEASURES

BREAST CANCER SCREENING (BCS)



Kaiser's *BCS* rate exceeded the MQD Quality Strategy target by 18.8 percentage points and was 37.8 percentage points above the lowest-performing QUEST health plan's rate, AlohaCare. HMSA performed 13.2 percentage points better than AlohaCare, and 5.8 percentage points below the MQD Quality Strategy target of 59.6 percent.

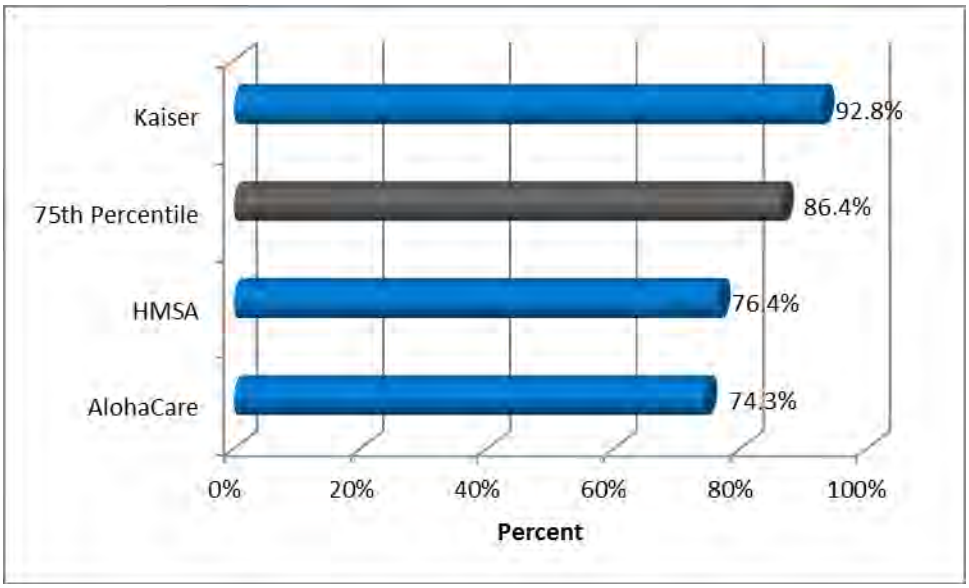
CHLAMYDIA SCREENING (CHL)



For the *CHL* measure, Kaiser performed 5.6 percentage points above the MQD Quality Strategy target of 63.7 percent. HMSA performed 1.7 percentage points below the target. AlohaCare's rate of 55.0 percent was the lowest among the QUEST health plans, performing 8.7 percentage points below the target.

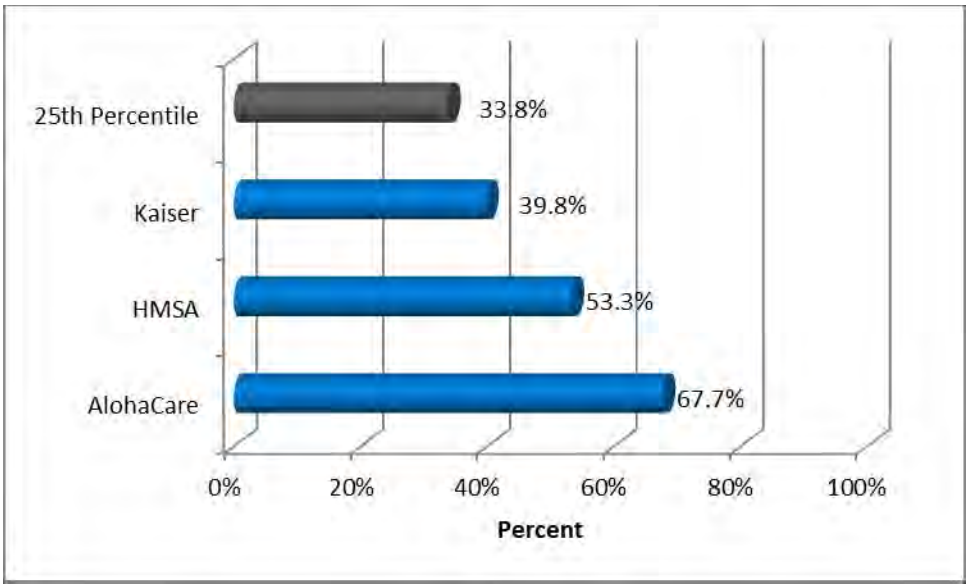
CARE FOR CHRONIC CONDITIONS

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C TESTING



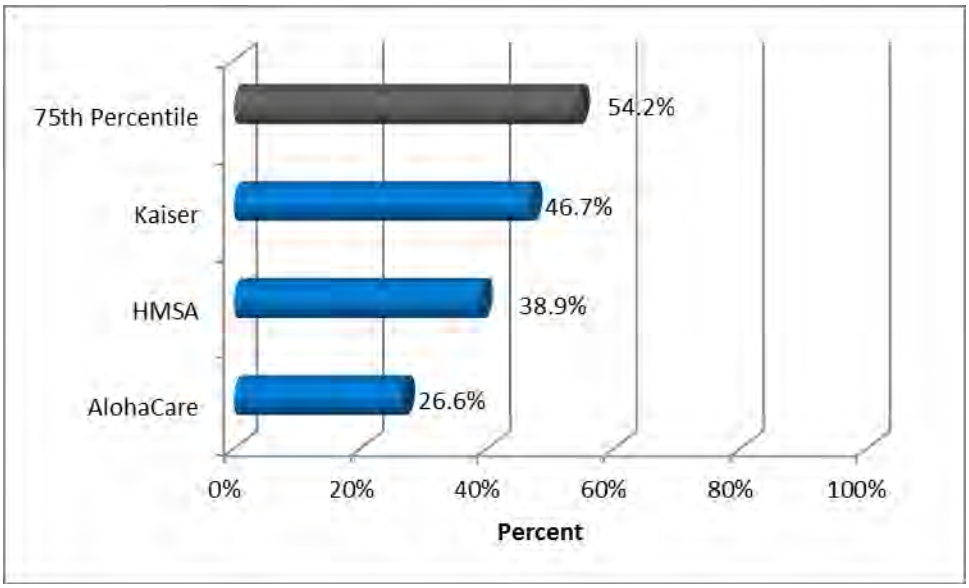
Kaiser was the top-performing QUEST health plan for the *HbA1c Testing* measure and AlohaCare was the lowest. Kaiser performed 6.4 percentage points above the MQD Quality Strategy target of 86.4 percent and exceeded the other two QUEST health plans by more than 16 percentage points.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C POOR CONTROL (>9.0%)



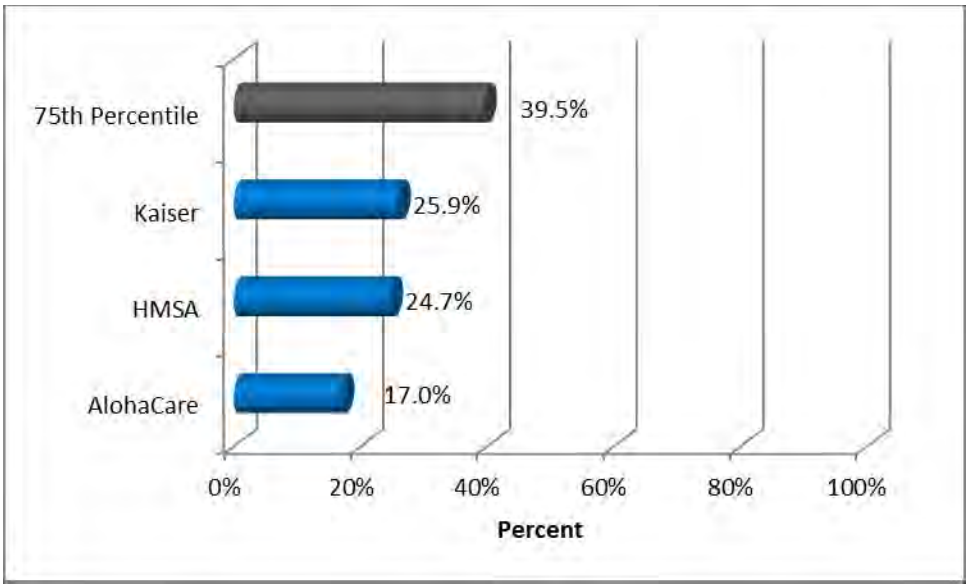
A lower rate for this measure represents better performance. None of the QUEST health plans performed better (lower) than the MQD Quality Strategy target of 33.8 percent. Kaiser's performance of 39.8 percent was the closest to the target set by the MQD with the other two QUEST health plans performing as much as 33.9 percentage points above the target.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C CONTROL (<8.0%)



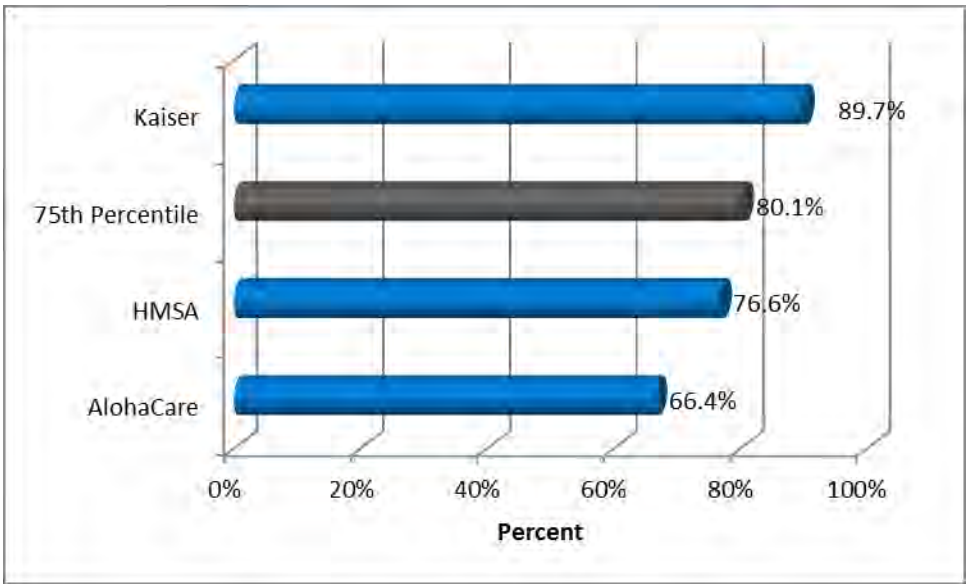
None of the QUEST health plans met the MQD Quality Strategy target of 54.2 percent for this measure. Kaiser's rate was higher than the other two QUEST plans by as much as 20 percentage points.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C CONTROL (<7.0%)



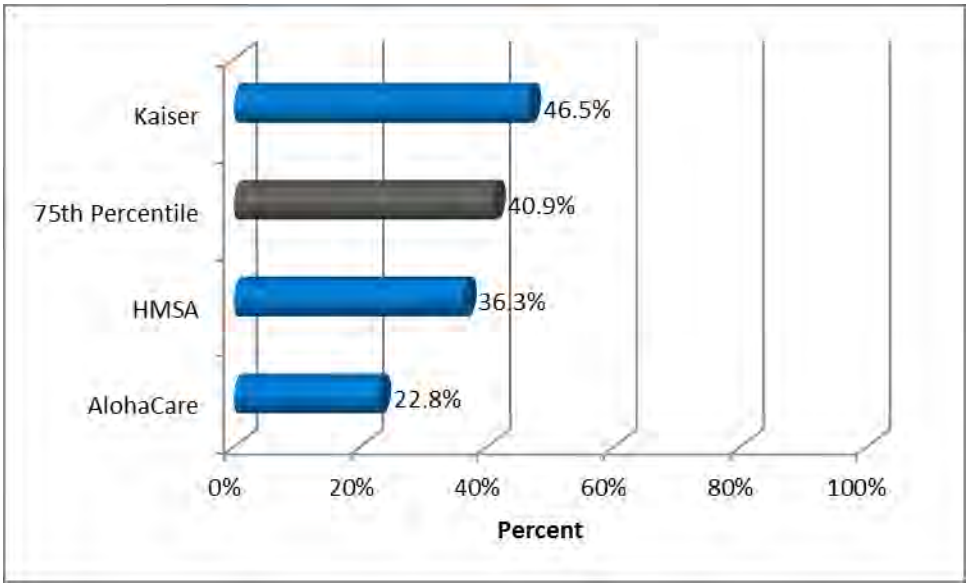
None of the QUEST health plans met the MQD Quality Strategy target of 39.5 percent for this measure; however, Kaiser's rate was the highest of the three plans. While the range of the QUEST health plan performance is only 8.9 percentage points, there is a difference of 22.5 percentage points between the lowest performing plan, AlohaCare, and the target.

COMPREHENSIVE DIABETES CARE (CDC)—LDL-C SCREENING



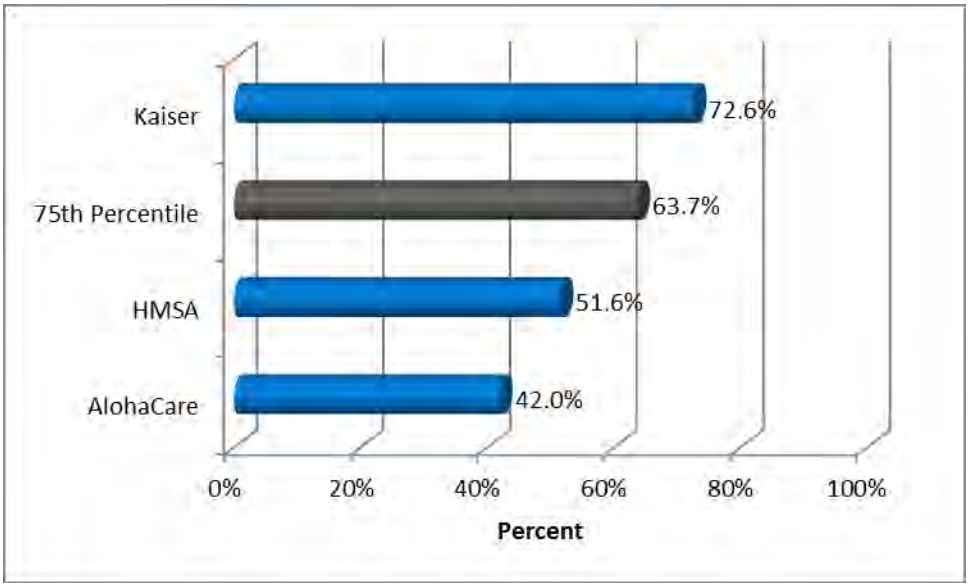
Kaiser was the top- performing QUEST health plan for the *LDL-C Screening* measure, exceeding both the MQD Quality Strategy target and the other two QUEST health plans' rates.

COMPREHENSIVE DIABETES CARE (CDC)—LDL-C CONTROL (<100 MG/DL)



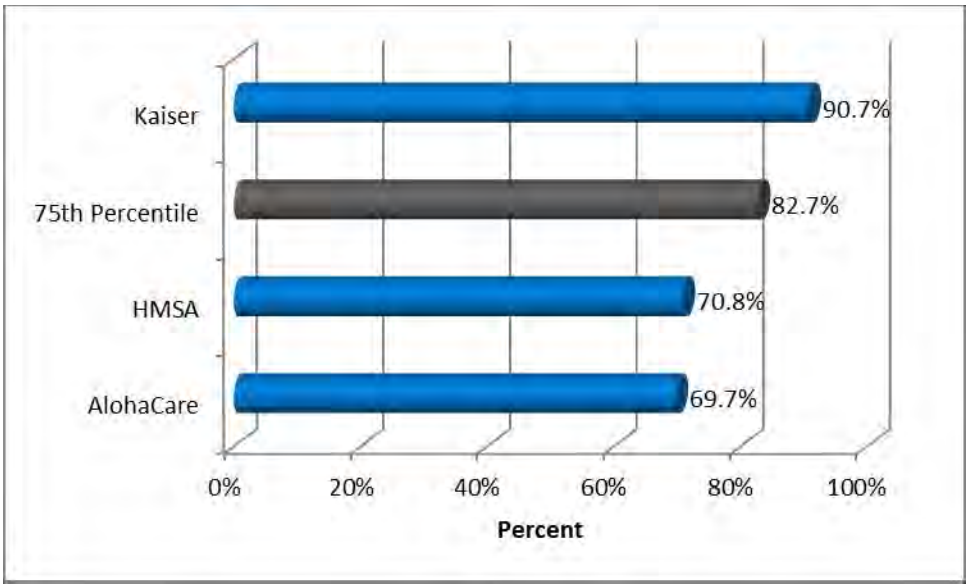
Kaiser was the top-performing QUEST health plan. Kaiser's *LDL-C Control* rate exceeded the MQD Quality Strategy target of 40.9 percent and the other two QUEST health plans' rates.

COMPREHENSIVE DIABETES CARE (CDC)—EYE EXAM



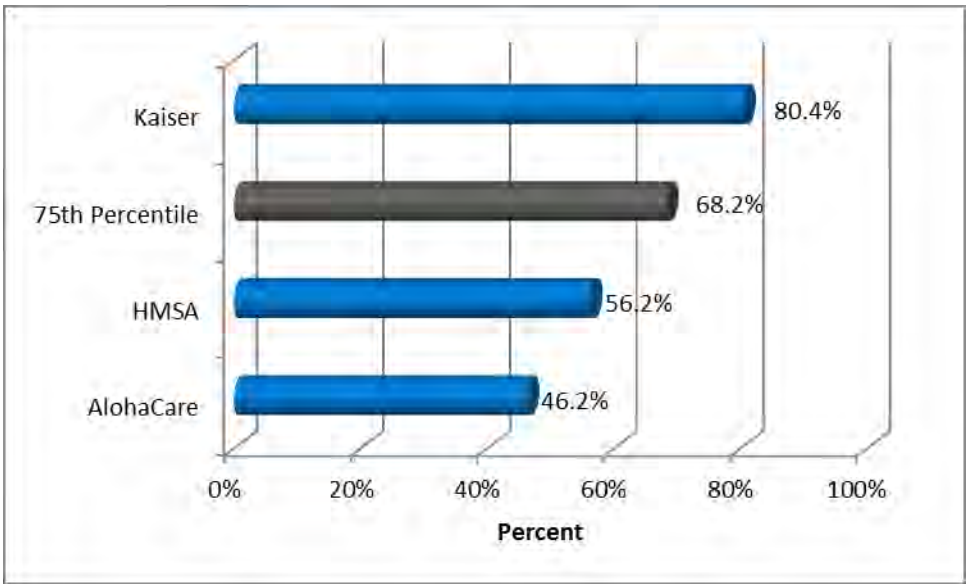
Kaiser was the only QUEST health plan to perform above the MQD Quality Strategy target of 63.7 percent for *Eye Exams.* The other two QUEST health plans performed as much as 21.7 percentage points below the target, with AlohaCare being the lowest performer.

COMPREHENSIVE DIABETES CARE (CDC)—MEDICAL ATTENTION FOR NEPHROPATHY



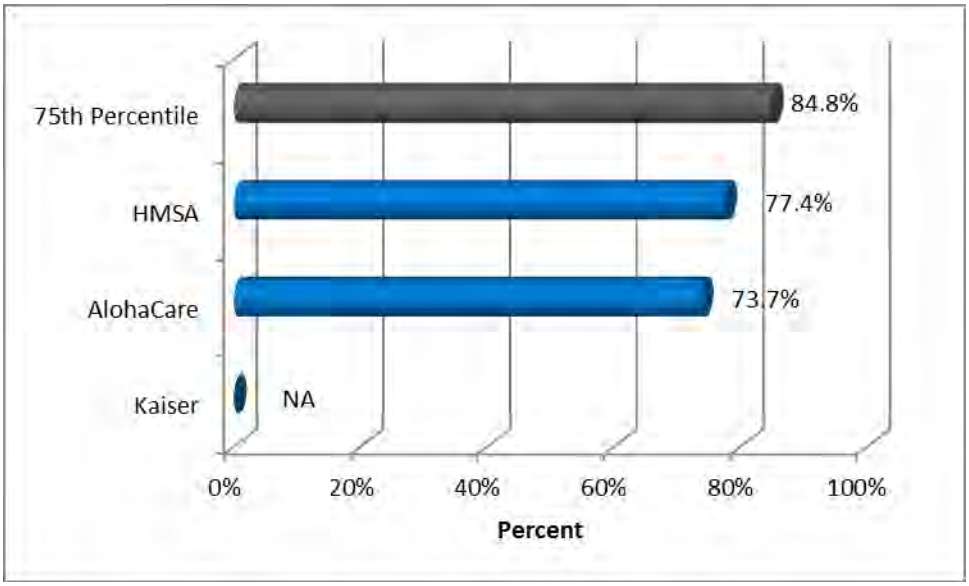
Kaiser exceeded the MQD Quality Strategy target of 82.7 percent by 8.0 percentage points and exceeded AlohaCare, the lowest-performing QUEST health plan, by 21.0 percentage points.

COMPREHENSIVE DIABETES CARE (CDC)—BLOOD PRESSURE CONTROL <140/90 MM HG



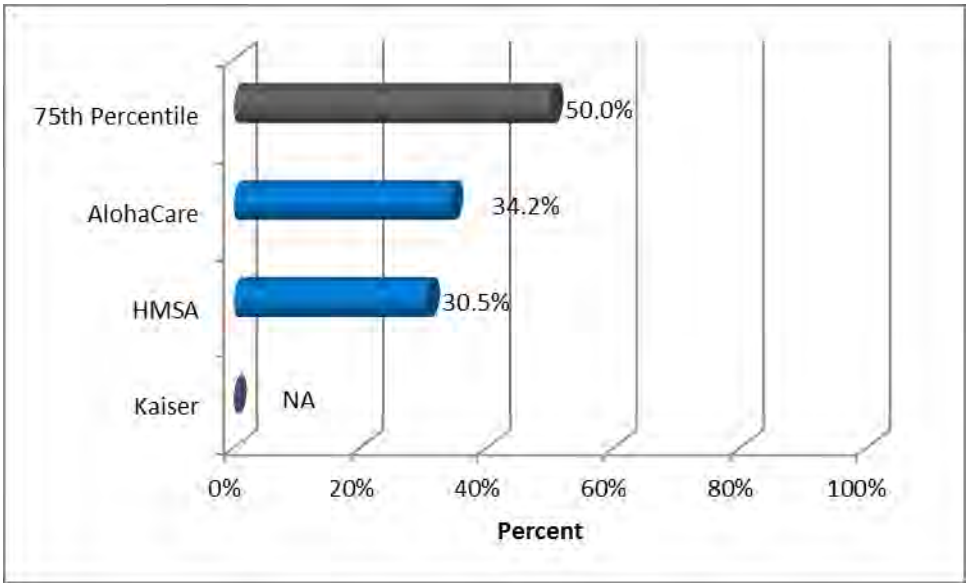
Kaiser's rate for *Blood Pressure Control* was 34.2 percentage points above AlohaCare's rate and 12.2 percentage points above the MQD Quality Strategy target of 68.2 percent. The other QUEST health plans performed below the target by as much as 22.0 percentage points.

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS (CMC)—SCREENING



None of the QUEST health plans met the MQD Quality Strategy target of 84.8 percent for the *CMC—Screening* measure. Kaiser reported an NA (*denominator <30)* for this measure as it did not have a population large enough to report a valid rate.

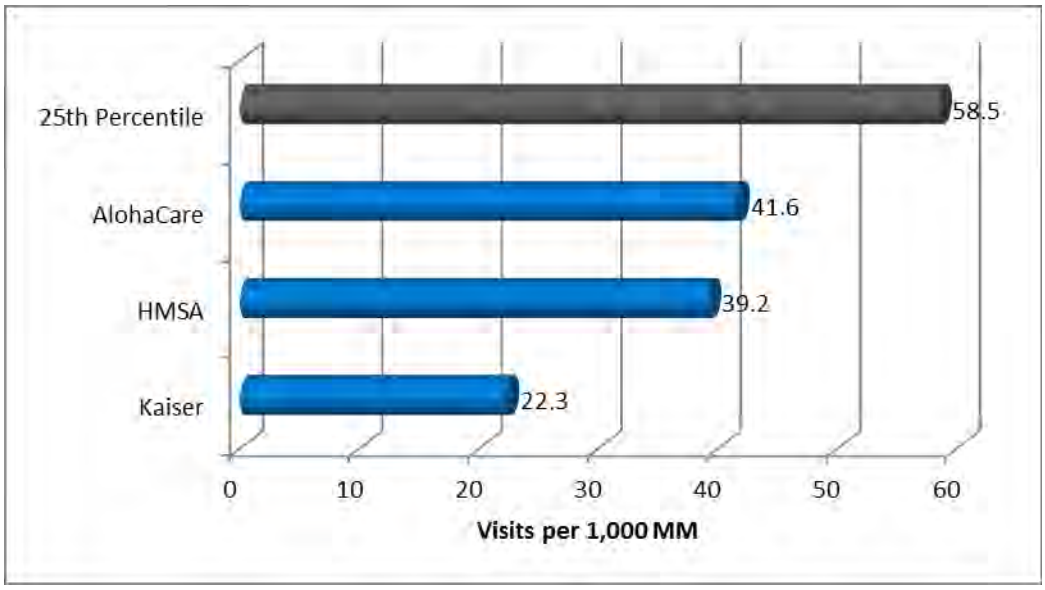
CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS (CMC)—CONTROL



None of the QUEST health plans met the MQD Quality Strategy target of 50.0 percent for the *CMC—Control* measure. Kaiser reported an NA (*denominator <30)* for this measure as it did not have a population large enough to report a valid rate.

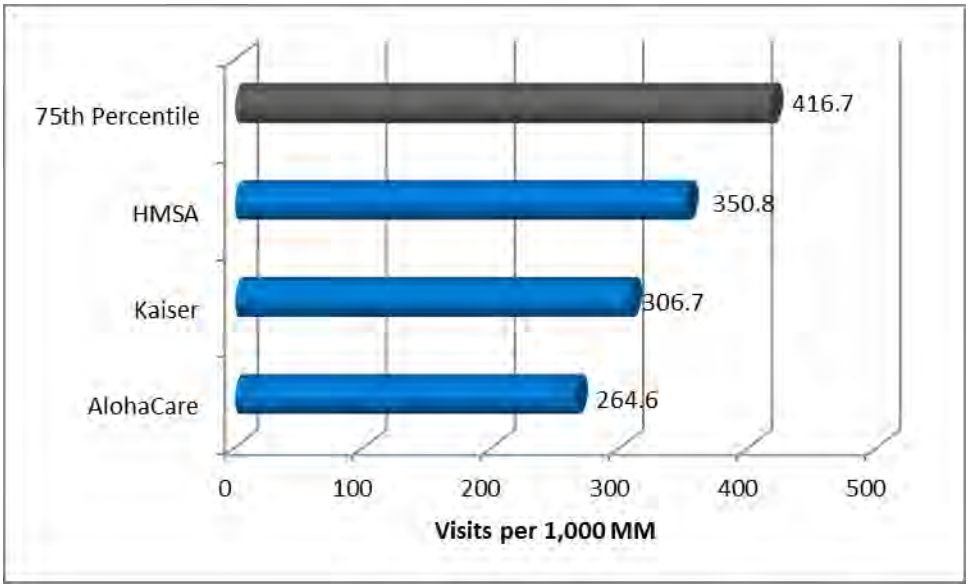
UTILIZATION MEASURES

AMBULATORY CARE —EMERGENCY DEPARTMENT (ED) VISITS PER 1,000 MM



All of the QUEST health plans demonstrated *ED Visit* rates lower than the MQD Quality Strategy target of 58.5 percent. Kaiser had the lowest rate and AlohaCare had the highest. Higher ED utilization may indicate an issue with member access to primary care physicians (PCPs) or other non-emergent after-hours care. However, some factors that impact ED utilization are out of a health plan's control. While the MQD Quality Strategy target is graphically displayed for reference, it is important to assess utilization based on the characteristics of the health plan's population and service delivery model.

AMBULATORY CARE —OUTPATIENT VISITS PER 1,000 MM



All of the QUEST health plans demonstrated *Outpatient Visits* rates below the MQD Quality Strategy target of 416.7 percent. It is important to assess outpatient utilization based on the characteristics of the health plan's population and service delivery model.

HEDIS Compliance Audits—QExA Health Plans

Table 4-3 compares each QExA health plan's compliance with the IS standard reviewed in a HEDIS compliance audit. As demonstrated below, all of the QUEST health plans were *Fully Compliant* with the IS standards that were applicable to the measures under the scope of the audit. The health plans were not required to report any of the HEDIS call center measures; therefore, IS 6.0 was *Not Applicable*.

Table 4-3—Validation of Performance Measures Comparison—QExA HEDIS Compliance Audit

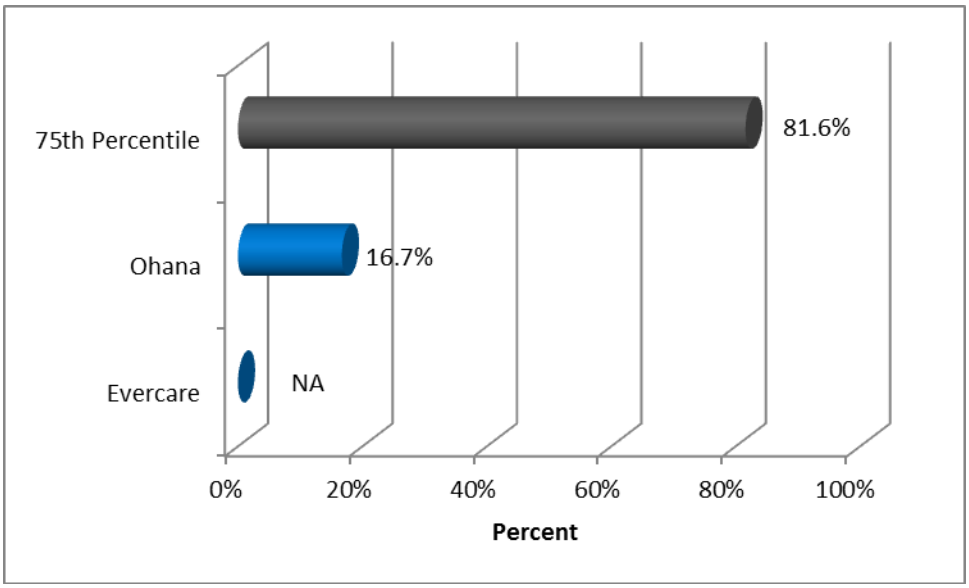
QExA Health Plan	Information Systems						
	IS 1.0 – Medical Data	*IS 2.0 – Enrollment Data*	*IS 3.0 – Provider Data*	*IS 4.0 – Medical Record Data*	*IS 5.0 – Supplemental Data*	*IS 6.0 – Call Center*	*IS 7.0 – Data Integration*
Evercare	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***
Ohana	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Fully Compliant***	***Not Applicable***	***Fully Compliant***

QExA HEDIS Performance Measures

The graphs below display the performance measure results for the QExA health plans' audited HEDIS 2011 measures compared to the MQD Quality Strategy targets for each measure. For most measures the MQD Quality Strategy target is the national HEDIS Medicaid 75th percentile. For those measures where a lower rate indicates better performance (i.e., *HbA1c Testing—Poor Control*, *Ambulatory Care—ED Visits)* the national HEDIS 2010 Medicaid 25th percentile was used as the MQD Quality Strategy target.

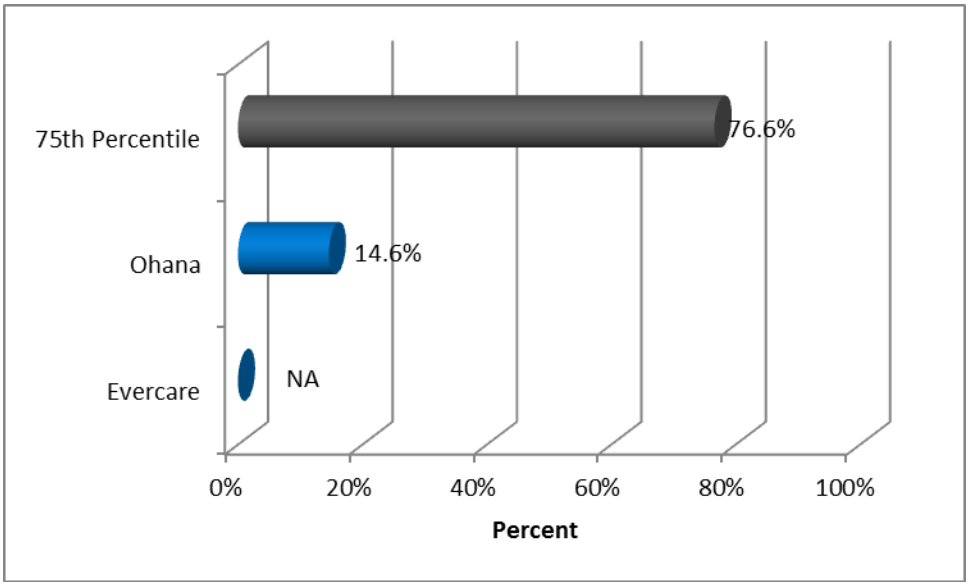
CHILDREN'S PREVENTION MEASURES

CHILDHOOD IMMUNIZATION STATUS (CIS)—COMBO 2



For the *CIS—Combo 2* measure, Ohana performed 64.9 percentage points below the MQD Quality Strategy target of 81.6 percent. Evercare reported an NA (*denominator <30*) as it did not have a population large enough to report a valid rate.

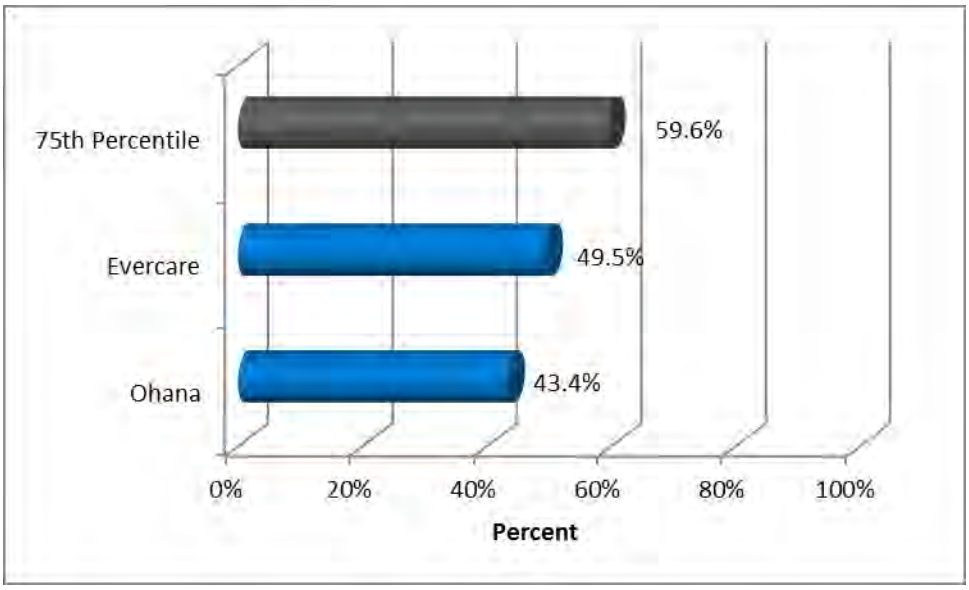
CHILDHOOD IMMUNIZATION STATUS (CIS)—COMBO 3



For the *CIS—Combo 3* measure, Ohana performed 62.0 percentage points below the MQD Quality Strategy target of 76.6 percent. Evercare reported an NA (*denominator <30*) as it did not have a population large enough to report a valid rate.

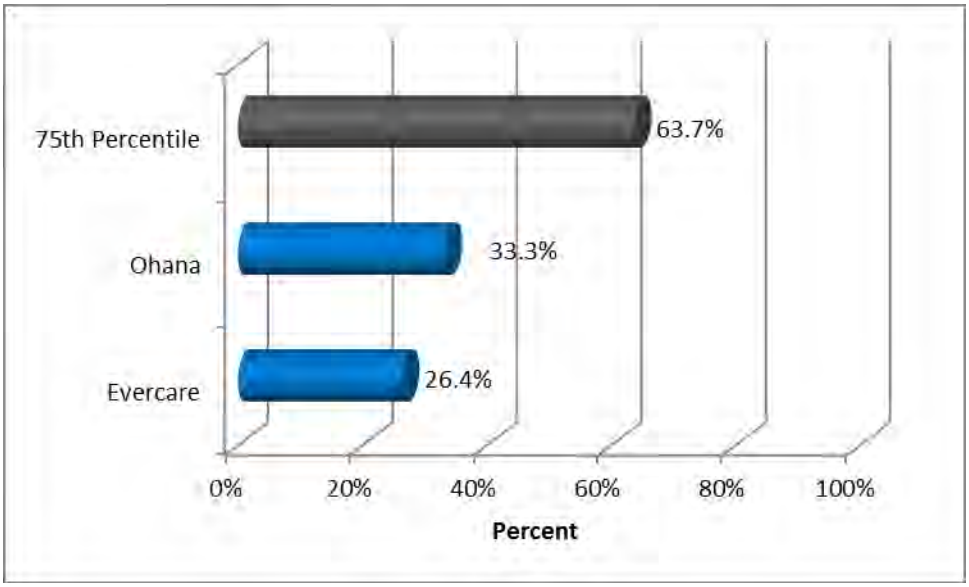
WOMEN'S HEALTH MEASURES

BREAST CANCER SCREENING (BCS)



Evercare's *BCS* rate exceeded Ohana's rate by 6.1 percentage points; however, both Ohana and Evercare performed below the MQD Quality Strategy target of 59.6 percent.

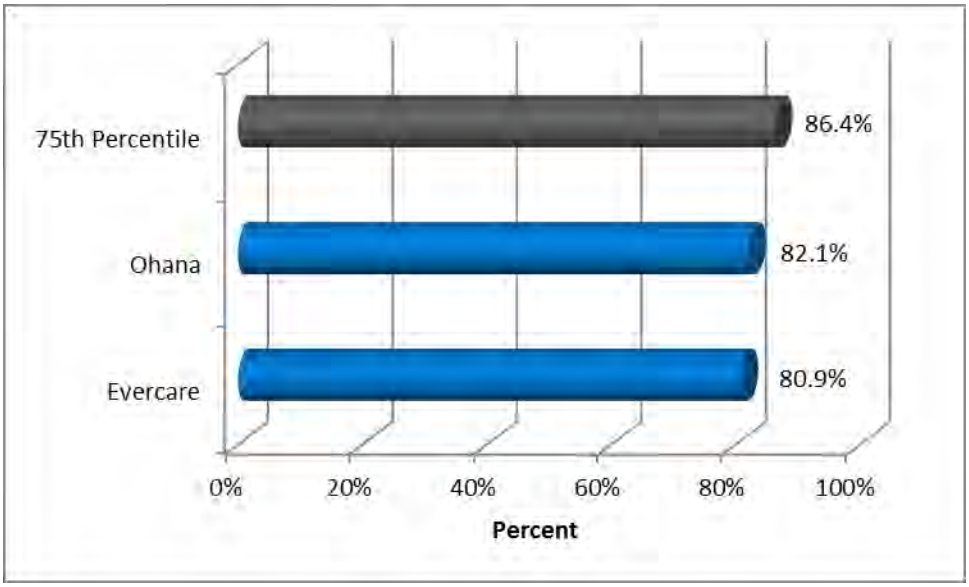
CHLAMYDIA SCREENING (CHL)



Ohana's *CHL* rate exceeded Evercare's rate by 6.9 percentage points; however, both QExA health plans' rates were below the MQD Quality Strategy target of 63.7 percent.

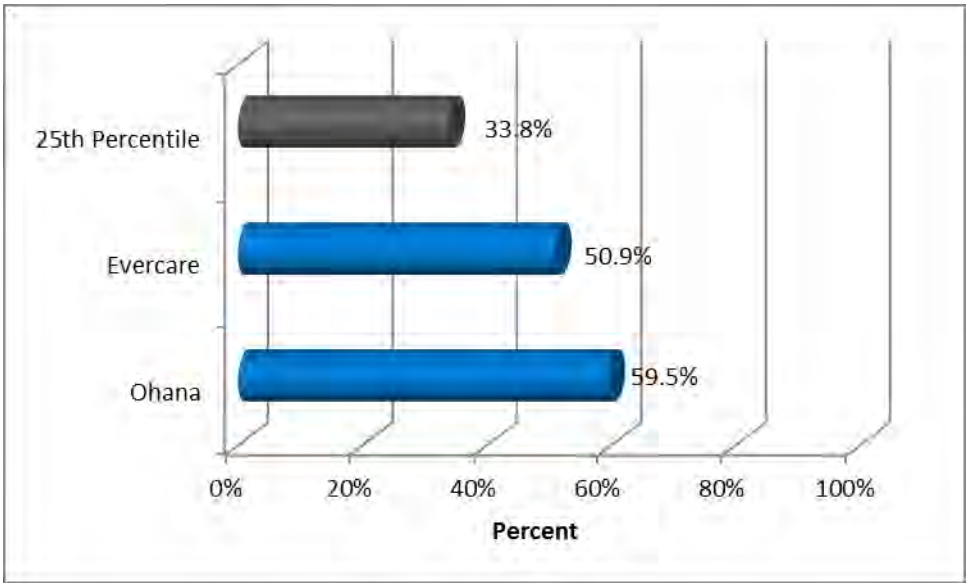
CARE FOR CHRONIC CONDITIONS

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C TESTING



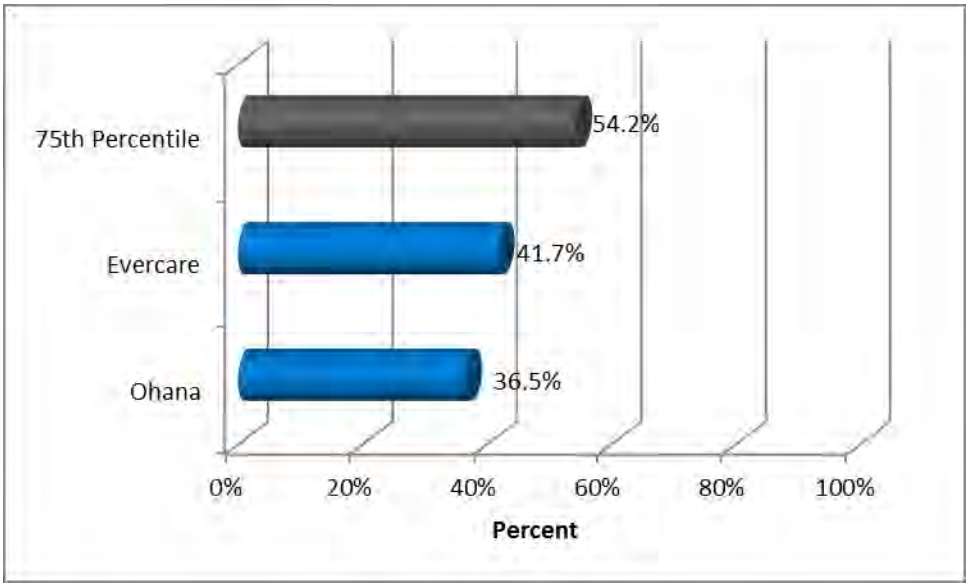
Ohana's *HbA1c Testing* rate was 1.2 percentage points above Evercare's rate; however, both QExA health plans performed below the MQD Quality Strategy target of 86.4 percent.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C POOR CONTROL (>9.0%)



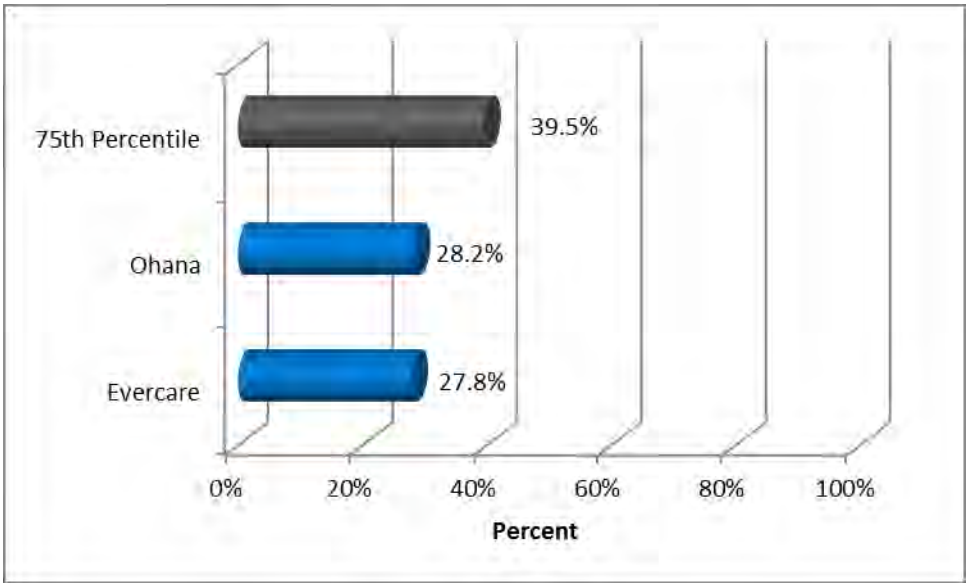
A lower rate for this measure represents better performance. Evercare performed better than Ohana; however, neither QExA health plan performed better (lower) than the MQD Quality Strategy target of 33.8 percent.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C CONTROL (<8.0%)



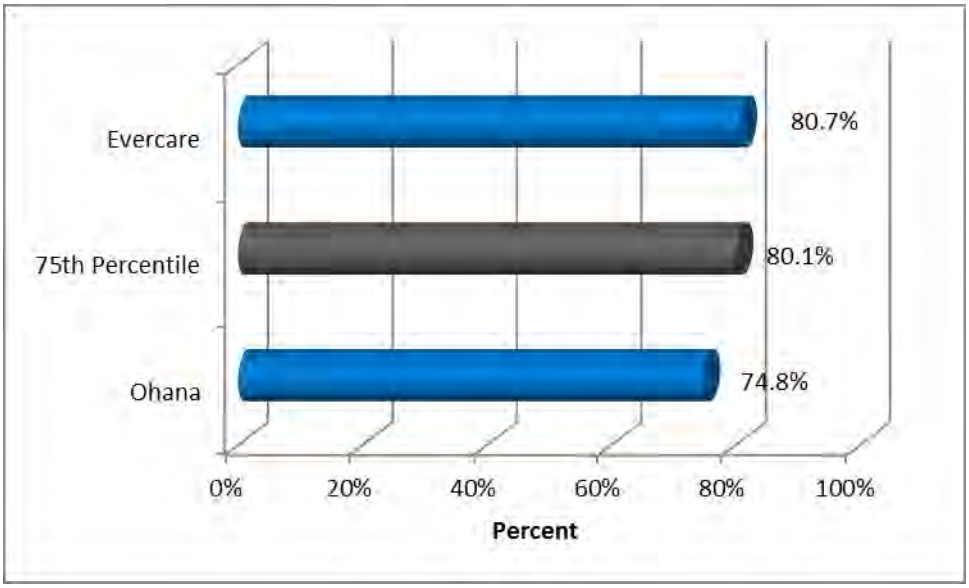
Evercare performed better than Ohana; however, neither of the QExA health plans met the MQD Quality Strategy target of 54.2 percent for this measure.

COMPREHENSIVE DIABETES CARE (CDC)—HBA1C CONTROL (<7.0%)



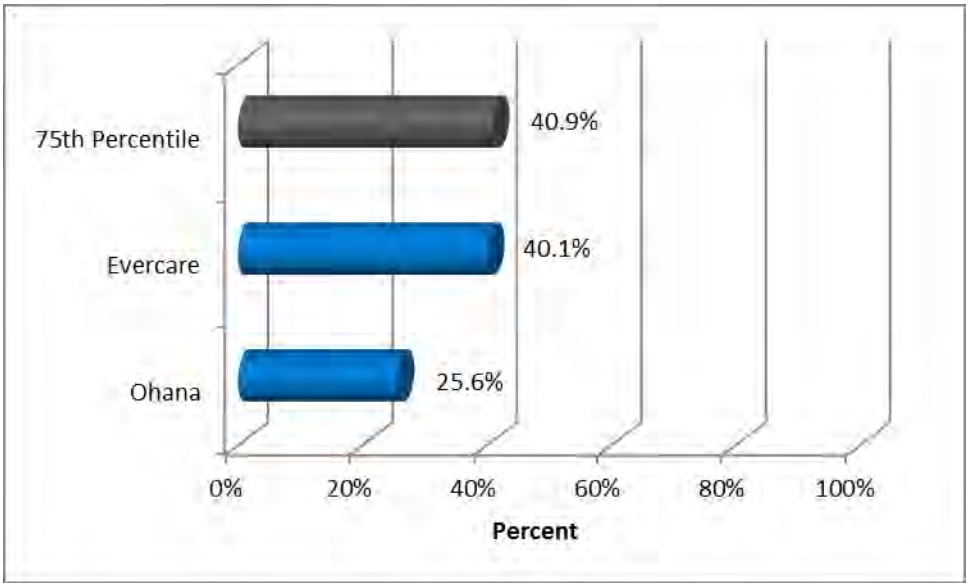
Ohana performed better than Evercare; however, neither QExA health plan met the MQD Quality Strategy target of 39.5 percent.

COMPREHENSIVE DIABETES CARE (CDC)—LDL-C SCREENING



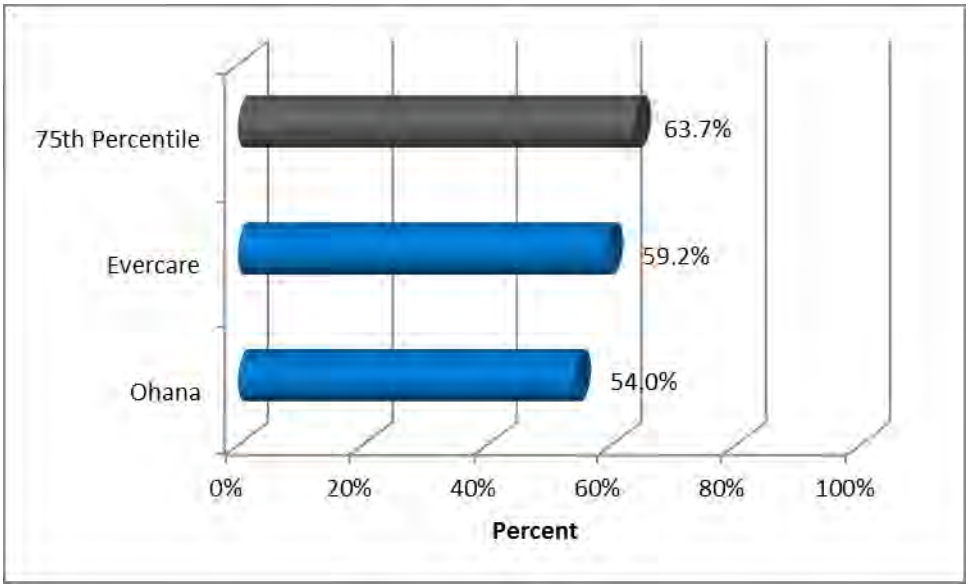
For the *LDL-C Screening* measure, Evercare exceeded the MQD Quality Strategy target of 80.1 percent and performed almost 6.0 percentage points above Ohana's rate.

COMPREHENSIVE DIABETES CARE (CDC)—LDL-C CONTROL (<100 MG/DL)



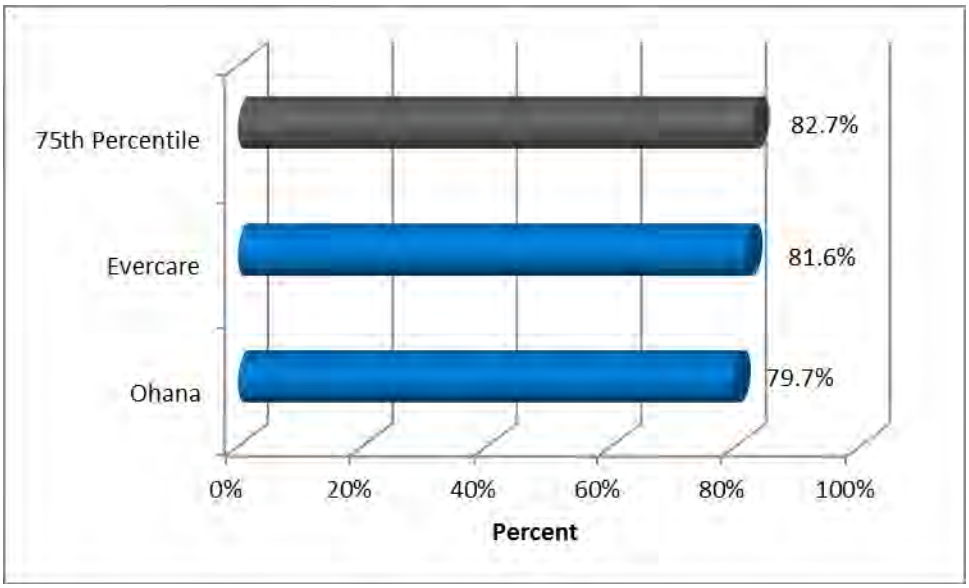
Evercare fell just below the MQD Quality Strategy target of 40.9 percent for this measure and exceeded Ohana's performance by 14.5 percentage points.

COMPREHENSIVE DIABETES CARE (CDC)—EYE EXAM



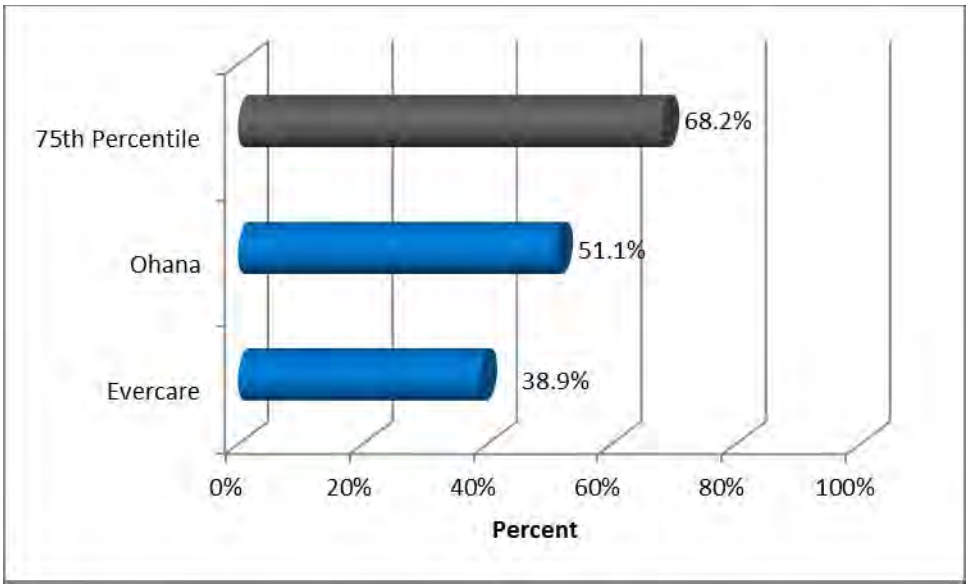
Neither of the QExA health plans met the MQD Quality Strategy target of 63.7 percent for this measure. While Evercare performed slightly better than Ohana, both still fell below the target.

COMPREHENSIVE DIABETES CARE (CDC)—MEDICAL ATTENTION FOR NEPHROPATHY



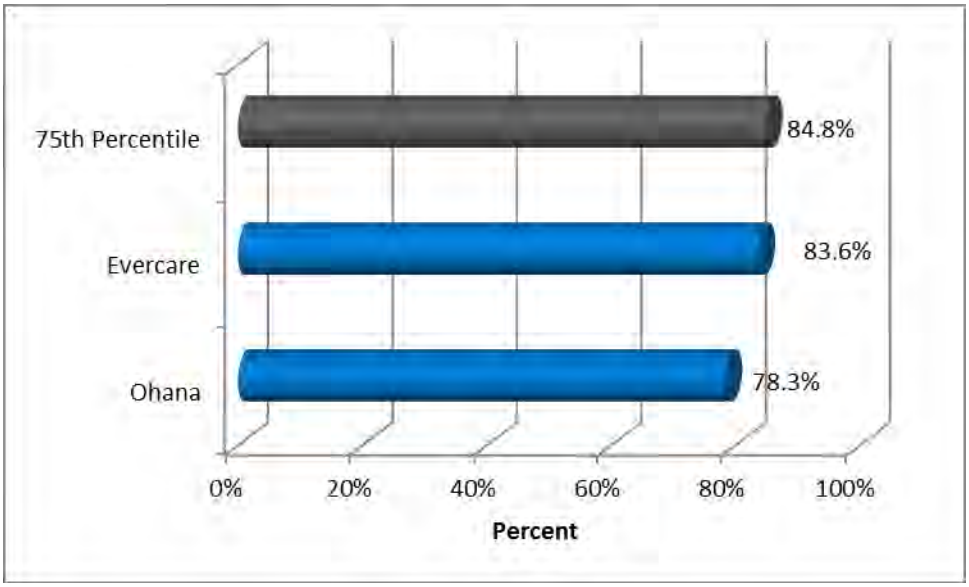
Although close, neither of the QExA health plans met the MQD Quality Strategy target of 82.7 percent for this measure. While Evercare performed slightly better than Ohana, both still fell below the target.

COMPREHENSIVE DIABETES CARE (CDC)—BLOOD PRESSURE CONTROL <140/90 MM HG



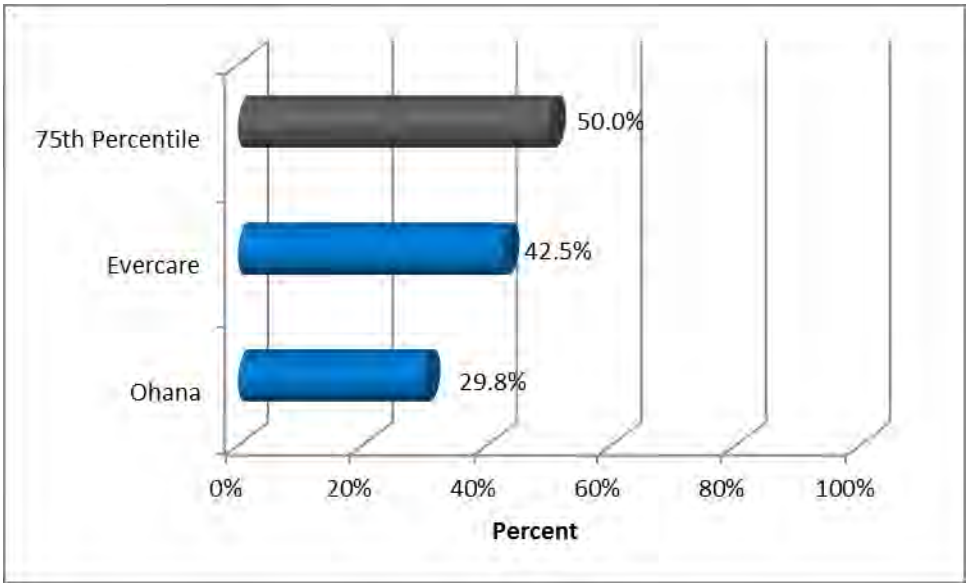
Neither of the QExA health plans met the MQD Quality Strategy target of 68.2 percent for this measure. Ohana exceeded Evercare's performance by 12.2 percentage points.

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS (CMC)—SCREENING



Evercare's rate for the *CMC—Screening* measure was 1.2 percentage points below the MQD Quality Strategy target of 84.8 percent and exceeded Ohana's rate of 78.3 percent by 5.3 percentage points.

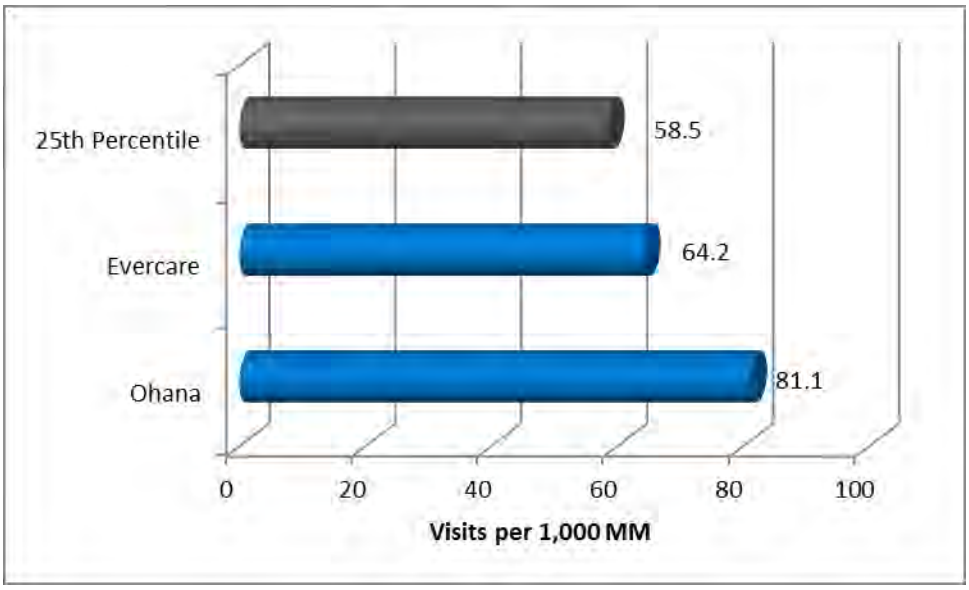
CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS (CMC)—CONTROL



Evercare performed better than Ohana by 12.7 percentage points, but both QExA health plans performed below the MQD Quality Strategy target of 50.0 percent.

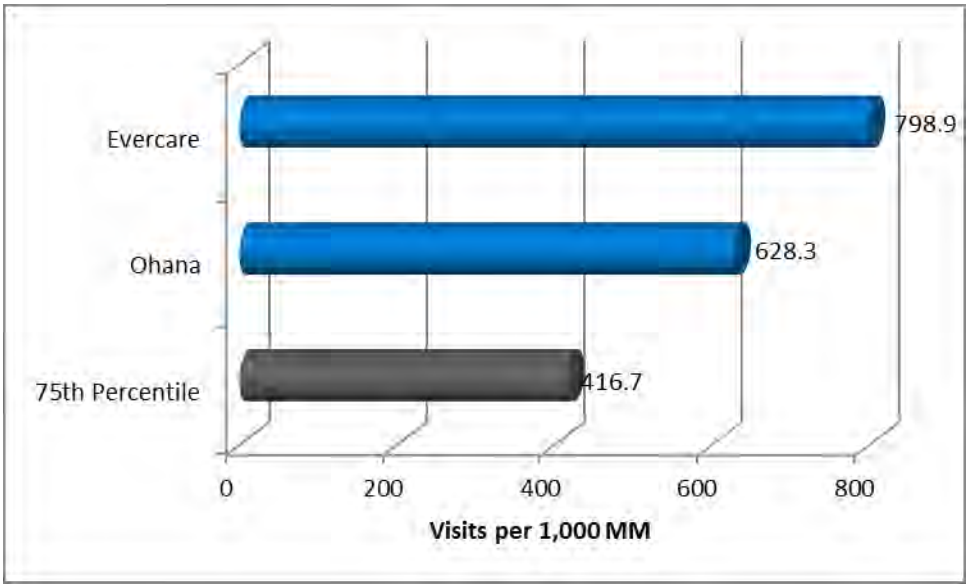
UTILIZATION MEASURES

AMBULATORY CARE—EMERGENCY DEPARTMENT (ED) VISITS PER 1,000 MM



Both of the QExA health plans demonstrated *ED Visit* rates higher than the MQD Quality Strategy target of 58.5 percent. Higher ED utilization may indicate an issue with member access to primary care physicians (PCPs) or other non-emergent after-hours care. However, some factors that impact ED utilization are out of a health plan's control. While the MQD Quality Strategy target is graphically displayed for reference, it is important to assess utilization based on the characteristics of the health plan's population and service delivery model. Members enrolled in the QExA health plans largely represent dual eligibles and include aged, blind, or disabled members. This population could contribute to higher ED visit rates compared to rates seen among the QUEST health plans.

AMBULATORY CARE —OUTPATIENT VISITS PER 1,000 MM



Both Ohana and Evercare's rates for *Outpatient Visits* performed above the MQD Quality Strategy target of 416.7 percent. It is important to assess outpatient utilization based on the characteristics of the plan's population and service delivery model. Members enrolled in the QExA health plans largely represent dual eligibles and include aged, blind, or disabled members. This population could contribute to higher outpatient visit rates compared to rates seen among the QUEST health plans.

Validation of Performance Improvement Projects

Validity of Performance Improvement Projects for QUEST Health Plans

HSAG conducted a review of two PIPs for each of the three QUEST plans—AlohaCare, HMSA, and Kaiser. For each QUEST plan, Table 4-4 shows the aggregate number of applicable evaluation elements that were scored *Met* for each study stage and the combined overall percentage of evaluation elements *Met* for both PIPs.

Table 4-4—2011 Performance Improvement Project Validation Results Comparison by Health Plan (N=6 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*		
		QUEST Health Plans		
		AlohaCare	HMSA	Kaiser
Design	Activities I–IV	100%	100%	100%
Implementation	Activities V–VII	94%	100%	100%
Outcomes	Activities VIII–X	72%	88%	81%
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**89%**	**96%**	**94%**

All three QUEST health plans met 100 percent of the requirements across all six PIPs for all four activities within the Design stage. Overall, the health plans designed scientifically sound studies that were supported by the use of key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes associated with the health plans' improvement strategies. The solid design of the PIPs allowed the successful progression to the next stage of the PIP process.

AlohaCare demonstrated the lowest score for the Implementation stage, while the other two health plans demonstrated a better application of intervention strategies. AlohaCare did not consistently document the implementation of its improvement strategies. Without the successful implementation of appropriate improvement strategies, the health plan cannot achieve and sustain improved outcomes in the future.

All three health plans scored the lowest for the Outcomes stage compared to the other two stages. AlohaCare's score was significantly lower than either HMSA or Kaiser. The execution of the intervention strategies across all six PIPs was inconsistent and resulted in mixed outcomes for the study indicators.

All six PIPs received a *Met* validation status.

Validity of Performance Improvement Projects for QExA Health Plans

HSAG conducted a review of two PIPs for each of the two QExA plans—Evercare and Ohana. For each QExA plan, Table 4-5 shows the aggregate number of applicable evaluation elements that

were scored *Met* for each study stage and the combined overall percentage of evaluation elements *Met* for both PIPs.

Table 4-5—2011 Performance Improvement Project Validation Results Comparison by Health Plan (N=4 PIPs)			
Study Stage	Activities	Percentage of Applicable Elements Scored *Met*	
		QExA Health Plans	
		Evercare	Ohana
Design	Activities I–IV	100%	88%
Implementation	Activities V–VII	100%	81%
Outcomes	Activities VIII–X	‡	50%
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**80%**
‡The PIP did not progress to this stage.			

Evercare adequately documented the necessary validation components for its PIPs. The Evercare PIPs were technically sound, and both PIPs received a *Met* validation status. For Ohana, only the diabetes PIP received a *Met* validation status. For the obesity PIP, Ohana did not adequately describe the sampling techniques, the data collection process, or accurately report the results; therefore, this PIP received a *Not Met* validation status.

QUEST Performance Improvement Projects

Table 4-6 and Table 4-7 display the outcome data for the QUEST health plans' PIPs. For the BMI PIPs, each health plan used the same study indicators, which allowed comparison of results across the health plans. Detailed study indicator descriptions, as well as rates for each measurement period are provided in Section 3.

Table 4-6—2011 Performance Improvement Project Outcomes Comparison by QUEST Health Plan PIP Outcomes—*Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form* Remeasurement 1 Period 10/1/09–9/30/10						
Study Indicator	**AlohaCare**		**HMSA**		**Kaiser**	
1) Percentage of Children With Weight and Height Recorded on the EPSDT Form.	94.2%	↓*	98.5%	↑*	99.0%	↑*
2) Percentage of Children With BMI Recorded on the EPSDT Form	62.0%	↑*	64.7%	↑*	99.1%	↑
3) Percentage of Children With BMI Percentile Recorded on the EPSDT Form.	33.0%	Not Assessed¥	30.4%	↑*	74.0%	↑*
4) Percentage of Children With Referral for Weight Counseling if BMI Percentile Equal to or Greater Than 95.	1.2%	Not Assessed¥	1.0%	↓*	100.0%	↑*

↑↓ Arrows designate any increase (↑) or decrease (↓) from the prior measurement period.

* Designates a statistically significant difference from the prior measurement period (p value < 0.05).

¥ AlohaCare was unable to collect data for Study Indicators 3 and 4 until 10/1/09; therefore, only the baseline period of 10/1/09–9/30/10 was submitted for validation and improvement could not be assessed.

For the first study indicator, both HMSA and Kaiser reported statistically significant increases while AlohaCare reported a statistically significant decrease. All three health plans documented increases for the second study indicator; however, the increase was not statistically significant for Kaiser. Both HMSA and Kaiser showed statistically significant improvement for the third study indicator. Kaiser also reported a statistically significant increase for the fourth study indicator while HMSA reported a statistically significant decline in performance.

For the access to care PIPs, each health plan selected different study indicators; therefore, comparisons across the health plans could not be made. The results are presented only as the number of study indicators instead of specific study indicator rates.

Table 4-7—2011 Performance Improvement Project Outcomes for Access to Care Topic Comparison by QUEST Health Plan				
PIP Topic[1]	Comparison to Study Indicator Results from Prior Measurement Period			Sustained Improvement
	Statistically Significant Decline	No Real Change	Statistically Significant Improvement	
AlohaCare (N = 4)				
Children's and Adolescents' Access to Primary Care	1	3	0	No
HMSA (N = 1)				
Well-Child Visits in the First 15 Months of Life	0	0	1	‡
Kaiser (N = 1)				
Access to Care	0	1	0	‡

[1]For the access to care PIP topic, the number of study indicators chosen by each of the three health plans varies for a total of six study indicators (N = 6).
‡The PIP did not progress to the phase for which improvement and/or sustained improvement could be assessed.

AlohaCare had four study indicators; however, none of the indicators demonstrated statistically significant improvement. Instead, one study indicator showed a statistically significant decline in performance. HMSA reported statistically significant improvement for its single study indicator while Kaiser showed no real change for its single study indicator.

AlohaCare did not achieve sustained improvement for any of its study indicators.

QExA Performance Improvement Projects

Evercare did not progress to the point of reporting study indicator outcomes for the current validation year. Ohana reported baseline results only; therefore, the results could not be assessed for real or sustained improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

Top-Box Comparisons

QUEST HEALTH PLANS

Table 4-8 presents the question summary rates and global proportions for each QUEST health plan, the QUEST aggregate, and the 2010 NCQA national child Medicaid average.[4-1, 4-2]

Table 4-8—Comparison of 2011 QUEST CAHPS Results

	2010 NCQA National Child Medicaid Average	AlohaCare	HMSA	Kaiser	QUEST Aggregate
Global Ratings					
Rating of Health Plan	65.4%	67.4%	69.2%	73.4%	70.3%
Rating of All Health Care	60.0%	58.3%	63.4%	63.3%	62.0%
Rating of Personal Doctor	69.8%	71.9%	71.0%	78.5% ↑	74.0%
Rating of Specialist Seen Most Often	66.5%	NA	NA	70.6% ↑	59.9%
Composite Measures					
Getting Needed Care	53.2%	NA	50.8%	52.1%	49.0%
Getting Care Quickly	68.0%	59.7%	65.3%	69.1%	65.2%
How Well Doctors Communicate	73.2%	70.1% ↓	73.0%	81.5% ↑	75.3%
Customer Service	61.5%	NA	NA	NA	58.4%
Shared Decision Making	65.4%	64.1%	68.7%	70.2%	68.2%

NA indicates that a rate was not assigned because there were fewer than 100 respondents.

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2010 NCQA national child Medicaid average.

↑ indicates the score is higher than the QUEST aggregate by a statistically significant degree.
↓ indicates the score is lower than the QUEST aggregate by a statistically significant degree.

[4-1] NCQA national averages for 2011 were not available at the time this report was prepared; therefore, 2010 NCQA national averages are presented in this section.
[4-2] The QUEST aggregate results were derived from the combined results of the QUEST health plans. This includes results from plans with fewer than 100 respondents.

Comparison of the QUEST AlohaCare, HMSA, Kaiser, and aggregate scores to the 2010 NCQA national child Medicaid average revealed the following:

- The QUEST aggregate scores were above the NCQA national child Medicaid average on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- AlohaCare scored above the NCQA national child Medicaid average on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- HMSA scored above the NCQA national child Medicaid average on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Shared Decision Making*.
- Kaiser scored above the NCQA national child Medicaid average on seven measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

Comparison of the QUEST AlohaCare, HMSA, and Kaiser scores to the QUEST aggregate scores revealed the following:

- AlohaCare scored significantly lower than the QUEST aggregate on one measure, *How Well Doctors Communicate*.
- HMSA did not score significantly higher or lower than the QUEST aggregate on any of the measures.
- Kaiser scored significantly higher than the QUEST aggregate on three measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.

QExA HEALTH PLANS

Table 4-9 presents the question summary rates and global proportions for each QExA health plan, the QExA aggregate, and the 2010 NCQA national child Medicaid average.[4-3]

Table 4-9—Comparison of 2011 QExA CAHPS Results

	2010 NCQA National Child Medicaid Average	Evercare	Ohana	QExA Aggregate
Global Ratings				
Rating of Health Plan	65.4%	43.4%	40.9%	41.8%
Rating of All Health Care	60.0%	49.0%	47.6%	48.1%
Rating of Personal Doctor	69.8%	69.8%	67.8%	68.6%
Rating of Specialist Seen Most Often	66.5%	67.4%	61.6%	63.9%
Composite Measures				
Getting Needed Care	53.2%	38.5%	41.6%	40.3%
Getting Care Quickly	68.0%	58.0%	60.7%	59.7%
How Well Doctors Communicate	73.2%	74.4%	70.8%	72.1%
Customer Service	61.5%	NA	42.1%	38.9%
Shared Decision Making	65.4%	68.8%	67.4%	67.9%

NA indicates that a rate was not assigned because there were fewer than 100 respondents.

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2010 NCQA national child Medicaid average.

Comparison of the QExA Evercare, Ohana, and aggregate scores to the 2010 NCQA national child Medicaid average revealed the following:

- The QExA aggregate score was above the NCQA national child Medicaid average on one measure, *Shared Decision Making*.
- Evercare scored at or above the NCQA national child Medicaid average on four measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Shared Decision Making*.

[4-3] The QExA aggregate results were derived from the combined results of the QExA health plans. This includes results from plans with fewer than 100 respondents.

- Ohana scored above the NCQA national child Medicaid average on one measure, *Shared Decision Making*.

A comparison of the QExA plans' scores revealed that there were no statistically significant differences between the two plans.

NCQA Comparisons

QUEST HEALTH PLANS

Table 4-10 presents the overall member satisfaction ratings for the QUEST aggregate and health plans on each of the four global ratings.

Table 4-10—NCQA Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
QUEST Aggregate	★★★★	★★★★	★★★★★	★
AlohaCare	★★★	★★	★★★	**NA**
HMSA	★★★★	★★★★	★★★★	**NA**
Kaiser	★★★★★	★★★★	★★★★★	★★★★

Note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All the QUEST health plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the QUEST aggregate scores.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Table 4-11 presents the overall member satisfaction ratings for the QUEST aggregate and health plans for each of the five composite measures.

Table 4-11—NCQA Comparisons: Composite Measures					
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**	**Shared Decision Making**
QUEST Aggregate	★★	★★	★★★	★★	★★★★
AlohaCare	NA	★	★	NA	★★
HMSA	★★	★	★★★	NA	★★★★
Kaiser	★★	★★	★★★★★	NA	★★★★★

Note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All the QUEST health plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the QUEST aggregate scores.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

QExA Health Plans

Table 4-12 presents the overall member satisfaction ratings for the QExA aggregate and health plans on each of the four global ratings.

Table 4-12—NCQA Comparisons: Global Ratings				
Plan Name	**Rating of Health Plan**	**Rating of All Health Care**	**Rating of Personal Doctor**	**Rating of Specialist Seen Most Often**
QExA Aggregate	★	★	★★	★★★
Evercare	★	★	★★★	★★★
Ohana	★	★	★★	★★

Note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All the QExA health plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the QExA aggregate scores.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Table 4-13 presents the overall member satisfaction ratings for the QExA aggregate and health plans on each of the five composite measures.

Table 4-13—NCQA Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
QExA Aggregate	★	★	★★	★	★★★
Evercare	★	★	★★★	NA	★★★
Ohana	★	★	★	★	★★★

Note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All the QExA health plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the QExA aggregates scores.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Provider Survey

QUEST Health Plans

Table 4-14 presents a summary of the statistically significant differences between the "top-box" rates (i.e., percent satisfied) of the QUEST health plans.

Table 4-14—QUEST Summary of Results

	AlohaCare		HMSA		Kaiser	
General Positions						
Compensation Satisfaction	13.2%	▼	42.5%	▲	46.5%	▲
Timeliness of Claims Payments	28.9%	▼	68.3%	▲	56.2%	—
Health Plan Communication						
Knowledge	12.6%	▼	37.2%	—	56.6%	▲
Keep Informed	5.9%	▼	24.6%	—	39.3%	▲
Formulary						
Adequate formulary	8.0%	▼	23.2%	—	56.4%	▲
Adequate access to non-formulary drugs	4.9%	▼	14.4%	▼	52.3%	▲
Specialists						
Adequacy of Specialists	8.0%	▼	33.3%	—	61.3%	▲
Range of Specialists	5.6%	▼	29.9%	—	61.3%	▲
Referral Policy	11.5%	▼	25.5%	▼	60.4%	▲
Providing Quality Care						
Prior Authorization Process	12.9%	▼	25.6%	—	35.4%	▲
Referral Process	15.8%	▼	24.3%	▼	55.7%	▲
Formulary	10.8%	▼	19.6%	▼	52.2%	▲
Concurrent Review	10.8%	▼	18.2%	▼	43.6%	▲
Discharge Planning	4.1%	▼	10.6%	▼	50.9%	▲
Network of Hospitals	8.2%	▼	14.2%	▼	47.7%	▲
Behavioral Health						
Adequate Amount of Specialists	3.4%	▼	14.7%	—	35.0%	▲

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

The following is a summary of QUEST plan performance on the 16 measures evaluated for statistical differences:

- AlohaCare's performance was significantly lower than the aggregate performance of the other QUEST health plans on all 16 measures.
- HMSA's performance was significantly higher than the aggregate performance of the other QUEST health plans on two of the measures and significantly lower than the aggregate performance of the other QUEST health plans on seven of the measures.
- Kaiser's performance was significantly higher than the aggregate performance of the other QUEST health plans on 15 measures.

QExA Health Plans

Table 4-15 presents a summary of the statistically significant differences between the "top-box" rates (i.e., percent satisfied) of the QExA health plans.

Table 4-15—QExA Summary of Results				
	Evercare		Ohana	
General Positions				
Compensation Satisfaction	8.9%	▼	19.7%	—
Timeliness of Claims Payments	23.1%	▼	28.9%	—
Health Plan Communication				
Knowledge	6.5%	—	11.2%	—
Keep Informed	3.7%	—	5.9%	—
Formulary				
Adequate formulary	4.4%	—	10.1%	—
Adequate access to non-formulary drugs	2.8%	—	3.9%	—
Specialists				
Adequacy of Specialists	5.8%	—	6.2%	—
Range of Specialists	4.2%	—	5.5%	—
Referral Policy	5.9%	—	6.5%	—
Providing Quality Care				
Prior Authorization Process	9.7%	—	12.7%	—
Referral Process	10.3%	—	11.1%	—
Formulary	9.4%	—	11.6%	—
Concurrent Review	10.3%	—	13.1%	—
Discharge Planning	4.7%	—	6.9%	—
Network of Hospitals	6.4%	—	10.9%	—
Behavioral Health				
Adequate Amount of Specialists	3.3%	—	4.6%	—
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plan*				
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plan*				
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plan*				

The following is a summary of QExA plan performance on the 16 measures evaluated for statistical differences:

- Evercare's performance was significantly lower than the other QExA plan on two of measures.
- Ohana's performance was not significantly higher or lower than the other QExA plan on all 16 measures.

5. Assessment of Follow-up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the QUEST and QExA health plans addressed the improvement recommendations made by HSAG in the prior year (2010) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. A provider survey was not conducted in 2010.

The improvement activities were self-reported by each health plan. HSAG used this information to assess the degree to which the activities were responsive to the improvement opportunities.

Compliance Monitoring Review

AlohaCare

AlohaCare received recommendations related to ***access and availability of services*** to:

- Define an emergency medical condition consistent with the State's definition in all documents.
- Revise its member information concerning AlohaCare's directive to members to call their PCP if possibly experiencing an emergency situation.

HSAG re-assessed the above areas following AlohaCare's implementation of its corrective action plan (CAP) in January 2011 and found the health plan to be in full compliance.

AlohaCare also received recommendations related to ***coverage and authorization of services***. The recommendations were to:

- Revise and correct the time frames for mailing notice of action (NOA) letters in its policies and other documents and adhere to the required time frames.
- Revise and correct its process and documentation for extending time frames for making service authorization decisions and provide the member his/her grievance rights if there is disagreement with the health plan's decision to extend the decision time frame.
- Improve the accuracy, clarity, and readability of information provided to members in the NOAs.

HSAG's re-assessment of these areas found AlohaCare to be making progress; however, the plan required some continued follow-up monitoring by the MQD to ensure corrections to the deficiencies in these areas were effective and sustained.

HMSA

HMSA received recommendations related to ***access and availability of services*** to:

- Define an emergency medical condition in its policy consistent with the State's definition.

HMSA also received recommendations regarding its ***coverage and authorization of services*** practices. The recommendations were to:

- Develop and implement a process for active supervision of non-licensed staff making service authorization decisions.
- Develop and implement a process to ensure all service denial decisions are being made by appropriately qualified licensed health care professionals.
- Develop and implement a process to meet the timely notification requirement for members when a claim is denied.
- Revise its claims payment NOA to include the reason for the denial.

HSAG re-assessed all of these areas in December 2010 following HMSA's implementation of its CAP and found the health plan to be in full compliance.

Kaiser

Kaiser received recommendations related to ***access and availability of services*** to:

- Define an emergency medical condition in its policy consistent with the State's definition.
- Define poststabilization services in its policies and other documents.

HSAG re-assessed these areas in September 2010 following Kaiser's implementation of its CAP and found the health plan to be in full compliance.

Evercare

Evercare received a ***general*** recommendation to:

- Take steps to ensure its timely and thorough responsiveness to mandatory State and EQRO activities and information requests.

Evercare adequately addressed this recommendation as evidenced by its staffing, preparation, and documentation submitted during the follow-up compliance review by HSAG performed in December 2010.

Evercare received recommendations related to ***access and availability of services*** to:

- Define an emergency medical condition in its policy and provider manual consistent with the State's definition.
- Establish a mechanism to notify out-of-network providers serving its members that the plan's payment is considered payment in full and that providers cannot balance bill members for these services.

Evercare received a recommendation related to ***coordination and continuity of care*** to:

- Provide for ongoing monitoring of staff, providers, and delegates responsible for developing care plans and coordinating members' care consistent with their health and functional assessment.

Evercare received a recommendation related to ***practice guidelines*** to:

- Ensure that it includes participating providers in decisions to develop, adopt, and revise its practice guidelines.

Evercare received recommendations related to ***coverage and authorization of services*** to:

- Ensure consistent application of service authorization review criteria, develop and implement processes for supervision and monitoring of the authorization decisions made by its staff and its delegates, and ensure that policies accurately describe its processes.
- Ensure that its policies and procedures and those of its delegates were reviewed and revised to meet all federal and contract requirements for time frames for making standard and expedited authorization decisions and for extending time frames.

HSAG re-assessed all of the above areas in October 2010 following Evercare's implementation of its CAP and found the health plan to be in full compliance.

For the following areas of deficiency, Evercare was assessed to be making progress; however, the plan required continued follow-up monitoring and technical assistance by the MQD to ensure corrections to the deficiencies were effective and sustained. The MQD, therefore, performed ongoing review of Evercare's NOAs for several months to ensure they were accurate, timely sent, and understandable by members as required for all health plan authorization decisions and actions, including authorization decisions made by Evercare's delegates. The ***coverage and authorization of services*** CAP areas that remained open and subject to MQD guidance and monitoring were related to recommendations to:

- Ensure that its policies and procedures and those of its delegates were reviewed and revised to meet all federal and contract requirements for processing requests for initial and continuing authorization of services, and to develop and implement effective processes for ongoing and formal review of its delegates.
- Ensure that its policies and procedures and those of its delegates were reviewed and revised to meet all federal and contract requirements for providing the member and the requesting provider written notice of an adverse action according to the required time frames.
- Ensure that its policies and procedures and those of its delegates were reviewed and revised to meet all federal and contract requirements for time frames for mailing NOA letters, and ensure that for service authorization decisions not reached within the required time frames (which constitutes a denial and, thus, an adverse action), a letter is mailed on the date the time frame expires.
- Ensure that its policies and procedures and those of its delegates were reviewed and revised to meet all federal and contract requirements for time frames and processes when extending the decision time frame on a service authorization request, and revise its notice of extension letter to

include the member's right to file a grievance if the member disagrees with the decision of the health plan to take more time.

Ohana

Ohana received a recommendation related to ***access and availability of services*** to:

- Ensure that the cultural competency plan summary that it gives to providers (in the provider manual) includes a statement that the provider may obtain a full copy of the plan at no charge, and how to do so.

HSAG re-assessed the above area in January 2011 following Ohana's implementation of its CAP and found the health plan to be in full compliance.

For the following areas of deficiency, Ohana was assessed to be making progress; however, the plan required continued follow-up monitoring and technical guidance by the MQD to ensure corrections to the deficiencies were effective and sustained. The MQD, therefore, worked with Ohana and performed monitoring of NOAs, including an evaluation of language and readability of the member NOAs. The ***coverage and authorization of services*** CAP areas that remained open and subject to the MQD guidance and monitoring were related to recommendations to:

- Ensure that the information provided to members in the NOAs meets the requirement for readability and understanding by the member.
- Ensure that provider NOA letters clearly articulate the required written information to the provider related to the kind of action being taken.
- Perform regular monitoring to ensure that the NOA letters continue to be sent as required.

Validation of Performance Measures—HEDIS Compliance Audits

AlohaCare

AlohaCare received recommendations to take actions to improve five of its validated HEDIS rates. A recommendation was made for any measure for which one or more indicator rates did not meet or exceed the HEDIS 50th percentile. For AlohaCare, this included:

- ***Comprehensive Diabetes Care*:** All of the indicators were below the HEDIS 2009 Medicaid 50th percentile, with three indicators below the 10th percentile.
- ***Cholesterol Management for Patients With Cardiovascular Condition*:** The rate for the LDL-C Screening indicator ranked below the HEDIS 2009 Medicaid 50th percentile.
- ***Breast Cancer Screening*:** The rate ranked at the national HEDIS 2009 Medicaid 10th percentile.
- ***Chlamydia Screening in Women*:** The rate for screening for women ages 21-24 ranked below the national HEDIS 2009 Medicaid 50th percentile.

AlohaCare implemented the following general activities to impact all of its performance measures:

1. System Software Initiatives: AlohaCare continued to use and enhance its Mercury Care Management Software and Enhanced PCP Member Rosters which began development and implementation in 2009. These two efforts provide internal (care management) and external (provider) tools and information to improve case management and disease management of members.

2. Implementation of the Patient-Centered Health Care Home (PCHCH): Since mid-2009, AlohaCare has collaborated with the Hawaii Primary Care Association to develop and implement a model of the PCHCH in Hawaii. Four community health centers (CHCs) are actively engaged in the implementation process as pilot sites, and future plans include expansion of the model to all CHCs in Hawaii. The model focuses on improved access to care, improved care coordination by the primary care team, improved patient experience, and reduced costs of care. AlohaCare's care management staff members have attended joint training sessions with care management staff from the health centers and are developing methods of data and information sharing to improve care management of members with targeted chronic diseases.

AlohaCare also implemented several interventions related to measure-specific recommendations.

Improvement Activities Specific to Childhood Immunization Status

1. Member Education and Outreach:
   a. AlohaCare continued to annually feature articles about the importance of childhood immunizations in its member magazine and included cut-out charts with the recommended immunization schedule for parents to use to track their child's immunizations.
   b. AlohaCare sent pregnant members a prenatal packet that included EPSDT preventive health information and scheduling recommendations for childhood vaccinations, as well as the "Official Lifetime Hawai'i Immunization Record" card.
   c. AlohaCare sent new members an introductory letter with EPSDT preventive health information and a follow-up letter after six months as a reminder to schedule well-child/immunization visits. Members also receive an EPSDT letter reminder on their birthday; and those members who are behind in their EPSDT schedule receive monthly reminders, as well as follow-up telephone calls.

2. Provider Education:
   a. AlohaCare updated and mass distributed the AlohaCare EPSDT Manual, and published a "Quick Guide" to EPSDT services in the Winter 2010 issue of the provider newsletter, *Ku'i La Lono.*
   b. AlohaCare's EPSDT nurse visits EPSDT providers to follow up with training in requirements for EPSDT visits, immunizations, screening, and the opportunity to complete immunizations even during "sick" visits. She conducts medical record reviews and provides feedback on documentation and performance of EPSDT services.
   c. AlohaCare's clinical practice guideline, "Recommended Immunization Schedules for Persons Age 0 to 18 Years" is updated annually and made available to all participating providers through AlohaCare's Web site. Providers are informed about the guidelines through the quarterly provider newsletter.

3. Pay for Performance Incentives: In September 2009 AlohaCare launched its Quality Improvement Incentive Program (QIIP) for participating providers whereby providers could earn incentive payments for successfully completing quality improvement projects. Three large providers participated in projects focused on early childhood care during FY 2010. In FY 2011, this program was continued with an increased weighting on results, and three providers were able to achieve improvements in childhood immunizations (HEDIS Combo2).

4. Member Incentive Pilot: AlohaCare continued a pilot program it had launched in early 2010 to test the impact of a member incentive (a gift card) for completing recommended well-child visits and immunizations.

5. Data Completeness: To address data completeness challenges experienced in the Medicaid population, AlohaCare has supported efforts by DHS and the other QUEST plans to create an EPSDT database and a statewide immunization registry that would include data on immunizations provided by other State agencies, such as the Department of Health and the Department of Education.

Comprehensive Diabetes Care

1. Member Education and Outreach:
   a. The Summer 2011 issue of the member magazine featured two articles, "Double Trouble" and "Know your ABC" on the relationship of diabetes and chronic heart failure.
   b. AlohaCare's Disease Management Department coordinates outreach to identified diabetic members. Members are provided with information on the ABC test and the relationship and increased risk of heart attack and stroke associated with diabetes. Members are also provided a self-tracking mechanism for managing their diabetes and goals.

2. Provider Outreach: Providers with a high volume of members with elevated LDL levels are provided with a quarterly report notifying them of members who need additional care and follow-up.

3. Community Education: AlohaCare has provided grants through its Community Conscience Award Program to a number of agencies for programs to improve diabetes education in the community, such as:
   a. Hui Malama Ola Na Oiwi to develop and distribute educational materials on diabetes prevention and management, and
   b. Mental Health Kokua to create a unique diabetes self-management program for seniors ages 60 and older called the Honolulu Seniors Diabetes-Depression Project. The program will offer a psychological community-based networking approach to diabetes self management.

4. Pay for Performance Incentives: AlohaCare's Quality Improvement Incentive Program rewarded providers for successful completion of quality improvement projects. During the period from October 2010 through June 2011, five providers completed QI projects related to improving one or more measures for comprehensive diabetes care.

Cholesterol Screening for Patients With Cardiovascular Conditions

Although this measure was not specifically addressed in AlohaCare's current Quality Improvement Work Plan because of limited resources and different improvement priorities, certain related interventions that are underway will have also been directed at members with cardiovascular disease, such as efforts toward member and community education and outreach, and initiatives aimed at improving data completeness.

Breast Cancer Screening

Although this measure was not specifically addressed in AlohaCare's current Quality Improvement Work Plan because of limited resources and different improvement priorities, certain related interventions that are underway will have also been directed at members appropriate for breast cancer screenings, such as efforts toward member and community education and outreach, and provider support interventions.

Chlamydia Screening in Women

1. Member Education: The Winter 2010 and Spring 2011 issues of the member magazine included two articles, "Teen STD Screening" and "Get Screened!" on chlamydia awareness and education.

2. Provider Education and Outreach:
   a. In 2011, AlohaCare developed clinical practice guidelines for chlamydia screening and treatment.
   b. AlohaCare sends a quarterly report to providers of their female members ages 16–24 years of age who have been identified as sexually active. The report indicates whether or not these members have had at least one chlamydia test during the previous year.

3. Pay for Performance Incentives: As part of the QIIP in FY 2011, three providers increased their rates of testing for chlamydia.

4. Data Completeness: AlohaCare recognized a major barrier to improvement of this measure as data completeness. Many family planning services providers use the Hawaii Department of Health (DOH) laboratory for STD screening and do not bill AlohaCare. AlohaCare has engaged in discussions with the STD section of DOH about a data sharing agreement but has not been successful to date. AlohaCare is working directly with the providers requesting they notify AlohaCare of the DOH results as part of their administrative process.

HMSA

HMSA received recommendations to take actions to improve four of its validated HEDIS rates. A recommendation was made for any measure for which one or more indicator rates did not meet or exceed the HEDIS 50th percentile. For HMSA, this included:

- ***Childhood Immunization Status***: Compared to the previous year's rates, all antigen measures showed a decline. None of the immunization measures showed rates that were above the HEDIS 2008 Medicaid 50th percentile, suggesting a high-priority opportunity for improvement.
- ***Comprehensive Diabetes Care***: All indicators except the *LDL-C Screening* and *HbA1c Testing* indicator performed below the national average and, therefore, presented opportunities for improvement.
- ***Cholesterol Management for Patients With Cardiovascular Conditions***: The *LDL-C level <100* measure ranked below the 10th percentile, representing an opportunity for improvement, specifically in the area of cholesterol management and control.
- ***Chlamydia Screening in Women***: All three indicators were below the national average.

HMSA implemented the following improvement activities to address these measures:

Childhood Immunization Status

1. Continuation and enhancement of the ~~I~~Immunize by 2" reminder program: A series of reminder cards are sent to the parents of children turning 6 months old and again at15 months old to stress the importance of receiving all immunizations. The reminder card includes the vaccination schedule for children and lists all vaccinations in the order that they should be received. The vaccination schedule is provided by the Bright Future Web site and recommended by the American Academy of Pediatrics. In addition to the mailers, the parents of patients turning 20 months old also received a telephone call reminding them to complete the rest of the recommended immunizations by the child's second birthday. Starting in 2011, Immunize by 2 mail and telephonic reminders are now coupled with additional education on the importance of receiving well child visits by 15 months of age.

2. General education on immunizations: Information was published in articles in the QUEST member newsletter, *Island Scene* magazine, and on the HMSA Web site. The Web site has a link which allows members to access an online childhood immunization calculator, other resources, and links to educational materials.

3. Provider resources: The Childhood Immunizations Quick Reference Guide (QRG) continued to be distributed to assist providers and their office staff in achieving quality of care goals by understanding the Bright Futures immunizations schedule, and appropriate procedure codes for combination and independent vaccinations. In addition, pediatricians received reports of members turning 2 years old and were given the opportunity to request patient materials for immunizations. Providers also received a Pediatric Material Order Form which included a variety of office posters, member mailers, and member brochures provided by HMSA, the Hawaii Department of Health, and the Centers for Disease Control and Prevention. Materials created by HMSA included an educational office poster and brochure promoting the safety of childhood immunizations by discounting myths associated with immunizations.

Comprehensive Diabetes Care

1. Member screening reminders: Mailed and telephonic reminders were given to patients diagnosed with diabetes or taking related medications. For diabetics who had no record of an LDL-C screening or whose LDL-C value was greater than or equal to 100 mg/dL, letters reminding the patient to have an LDL-C screening were sent in March and July. To reinforce the messaging, reminder calls for those who had not received an LDL-C screening were performed in March, and in August reminder calls were expanded to include those with no record of an HbA1C test. Aside from regular reminders, members newly diagnosed with diabetes are routinely given a welcome call and assessment. In 2011, reminders for those with diabetes became more comprehensive to address the importance of receiving multiple services including LDL-C screenings, HbA1c tests, eye exams, and treatment for nephropathy. In May 2011, a checklist of needed services was sent to all QUEST members, reinforced by a call reminder. In addition, a Comprehensive Diabetes Quick Reference Guide (QRG) was created for primary care physicians and a Diabetes Eye Exams QRG was created for eye specialists to help providers and their office staff to achieve quality of care goals by understanding national best practice guidelines and appropriate diagnostic/procedure codes. 2011 reminders will be transitioned to re-occurring reminders that include dynamic member-specific reminders for preventive health screenings and select chronic condition screening reminders.

2. Individual and group member education: HMSA members also had the opportunity to access one-on-one and group classes with certified diabetes educators from around the State through HMSA's diabetes education provider network (DEPN). DEPN providers who teach individual self-management classes are board certified by the National Certification Board for Diabetes Educators. DEPN providers who teach group classes are actively certified by the American Diabetes Association (ADA) Certificate of Recognition or the American Association of Diabetes Educators (AADE) Certificate of Accreditation. Patients may self-refer, be referred by HMSA disease management support, or be referred by a provider.

3. Telephonic and print media member education: By similar means of referral, members with diabetes may also access HMSA's telephonic disease management services, which provide telephonic health coaching or counseling. Patients learn how to manage lifestyle factors including physical activity, nutrition, smoking cessation, medication management, and stress management. General education on the risks of diabetes, diabetes self-management tips, member stories, and HMSA resources to support those with diabetes can be found in the QUEST member newsletter and *Island Scene* magazine.

Cholesterol Management for Patients With Cardiovascular Conditions

Provider resource: In 2011, a Cholesterol Management Screening QRG was created to assist providers and their office staff in achieving quality of care goals. The QRG highlights ATP III guidelines for the cholesterol management of patients with heart disease and includes relevant ICD9 and CPT codes.

Chlamydia Screening in Women

1. Data collection: In addition to collecting information on chlamydia screenings via administrative claims data, HMSA created a supplemental database of data from Federally Qualified Health Centers (FQHCs). Chlamydia screening data do not always show up in administrative HMSA data for FQHCs because they do not bill HMSA regularly due to a federal grant that FQHCs received for the provision of these screening services. Thus, HMSA receives supplemental data separately from FQHCs, which includes a list of members who have received the screening as well as a sample of patients' electronic health records for primary source verification.

2. Provider resource: A Chlamydia Screening QRG was created, updated, and distributed to providers to assist them in achieving quality of care goals. The QRG highlights best practice guidelines and appropriate screening codes and informs providers on how to bill appropriately.

3. Member education: General education on the importance of chlamydia screenings is posted on HMSA.com in the Health and Wellness portal for members to access patient brochures, women's health recommendations, and additional resources which promote chlamydia screening.

Kaiser

Kaiser received recommendations to take actions to improve one of its validated HEDIS rates. A recommendation was made for any measure for which one or more indicator rates did not meet or exceed the HEDIS 50th percentile. For Kaiser, this included:

- ***Comprehensive Diabetes Care***: Kaiser performed better than the national HEDIS 2008 Medicaid 50th percentile on all of the diabetes measures with the exception of *HbA1c Poor Control*. This measure ranked above the HEDIS 50th percentile; and since it is a reverse measure (meaning that a lower rate indicates better performance), it represents an opportunity for improvement.

Kaiser reported that, through its Diabetes Care Management Program, it addressed all components of the recommendations relating to support groups, outreach, reminder systems, and health education programs. However, Kaiser did not provide specific information or descriptions of its interventions for this measure.

Evercare

Evercare received recommendations to take actions to improve three of its validated HEDIS rates. A recommendation was made for any measure for which one or more indicator rates did not meet or exceed the HEDIS 50th percentile. For Evercare, this included:

- ***Comprehensive Diabetes Care***: Evercare received an audit result of *Not Report (NR)* for six indicators for this measure—*LDL-C Control (<100 mg/dL), Blood Pressure Control (<130/80 mm Hg), Blood Pressure Control (<140/90 mm Hg), HbA1c Control (<7.0%), HbA1c Control (<8.0%)*, and *HbA1c Poor Control (>9.0%)*—since the plan chose not to report these rates.

HSAG recommended that the MQD require Evercare to take the necessary steps to be able to report all rates for the *CDC* measure, including requiring the hybrid methodology, if necessary. The MQD did communicate to the health plans the requirement for hybrid reporting of this and other select measures, beginning in CY 2011.

Two ***CDC*** indicators' rates were below the HEDIS 2009 Medicaid 50th percentiles: *LDL-C Screening* and *Eye Exam*, and the rate for the *HbA1c Testing* indicator was below the HEDIS 2009 Medicaid 10th percentile, all presenting opportunities for improvement.

- ***Ambulatory Care-ED Visits/1,000 Member Months***: One age group, 1–9 Years, scored above the HEDIS 2009 Medicaid 90th percentile, indicating higher utilization, as this is an inverted measure. Increased or above average utilization, particularly ED use, is generally a negative outcome, and may indicate an opportunity for further assessment and improvement actions.
- ***Chlamydia Screening in Women***: Evercare's rates were below the HEDIS 2009 Medicaid 10th percentiles for two of the *CHL* indicators, 16–20 Years and Total.

Evercare implemented the following improvement activities to address these measures:

Comprehensive Diabetes Care

1. Evercare initiated a process to use a number of community-based diabetic support groups, referring diabetic members to these existing community-based resources. Information about these resources and the diabetes disease management program was included in a provider toolkit sent to PCPs in mid-August 2011.

2. During 2010 and 2011, member newsletter topics for diabetes education included healthy eating, weight management, smoking cessation, blood pressure control, retinopathy and retinal eye exams, disease etiology and complications, blood sugar control, and kidney disease. Service coordinators implement individualized health education for members and caregivers as appropriate to their condition and learning needs.

3. Additional provider educational tools have been developed by UnitedHealthcare (UHC). These include:
   a. Education tools on HEDIS measures, including the *Comprehensive Diabetes Care* measure, were developed (called ~~"~~HEDIS in a box"). These tools were targeted to be sent to high-volume providers in September 2011.
   b. Provider-specific profiles that include patients' compliance with *CDC* diabetes measures were developed and scheduled to be distributed to the providers, along with a roster of those members on their panel, in September 2011.

4. UHC has a partnership with Sesame Street Workshop, the nonprofit educational organization behind Sesame Street, to promote healthy eating habits for children and families on limited budgets. In late 2010, Sesame Street Reading Corners were provided to FQHCs in Hawaii which consisted of child-sized tables, chairs, Sesame Street posters, and books highlighting wise food

choices. In 2011, Evercare planned to deliver specially-created Sesame Street healthy-living (and food for thought) kits—books, bookmarks, stickers, puzzles and DVDs—to Hawaii FQHCs.

5. Evercare's new diabetic members are identified via claims information, self-referral or referral by service coordinators and providers. Monthly, new members are sent a packet welcoming them to the diabetes management program. Service coordinators complete a secondary assessment for members with a diagnosis of diabetes during their regularly scheduled assessments, and member/caregiver education is customized to the needs of the individual.

6. The plan conducted hybrid measurement for HEDIS 2011.

7. UHC has developed a national quality strategy which includes the goal to improve the Hawaii plan's *CDC* HEDIS measure by 3 percent in 2012. Strategy implementation steps and timelines have been developed. Interventions include:
   a. Reminder cards direct mailing to members for needed screenings and tests.
   b. A report of members who have not received the needed services within six months of the mailing will be available for tracking and follow-up by health plan staff (targeted to begin in January 2012).
   c. A Universal Tracking Database (UTD) has been developed to document outreach and to track interventions for preventive screening measures. A link between the Care Management documentation system and the UTD is being developed to facilitate timely, easy access to the UTD system, making information readily available to disease management and care management staff. Training of staff on the system is targeted to occur once the programming enhancements are complete (December 2011).
   d. HEDIS-like data metrics have been developed for quarterly monitoring of performance measures associated with diabetes care and to facilitate the trigger of timely interventions when performance is less than optimal.

Ambulatory Care—ED Visits/1,000 Member Months

UHC Evercare currently monitors several utilization measures to analyze effectiveness of care systems. Following data analysis, these targeted interventions were implemented in response to utilization outcomes:

1. Service coordinators conduct post-hospitalization assessments within three days of discharge to assure that appropriate services are in place to support the member's care.

2. Complex Case Management (CCM) is conducted on individual members who meet the criteria for high utilization or otherwise are at risk for institutionalization. Once identified for CCM, Evercare service coordinators perform assessments to complete a comprehensive evaluation of member needs and risk factors based on national clinical guidelines and recognized risk factors. An individualized plan of care is developed based on the member's responses to both the comprehensive and disease-specific assessment questions. Member contact frequency for follow-up is established based on the member's medical needs and/or medical/psycho-social status/needs, but must occur at least monthly.

3. Evercare conducted member education to promote the regular use of a PCP. Member newsletters published in 2010 and 2011 covered the following topics:
   a. What is considered an emergency
   b. Finding a doctor and PCP
   c. Appointment standards
   d. Making your PCP your partner in health
   e. Options for the right care in the right place

4. Provider education was also conducted on Appointment and After-Hours Accessibility standards in the Fall 2010 provider newsletter.

5. A population assessment was completed by Evercare to determine those characteristics of the membership that may require targeted interventions. The results of the assessment analysis will determine future interventions as appropriate for the plan.

Chlamydia Screening in Women

1. In their Spring 2011 member newsletter, Evercare conducted member education on STDs, the risk of cervical cancer, and the importance of seeing a physician regularly.

2. Evercare's Physician Advisory Council adopted national Clinical Practice Guidelines (CPGs) for 2011 which included preventive health screening guidelines. The local Provider Advisory Committee reviewed and adopted these guidelines for the QExA members. The CPGs were communicated to physician providers via the Spring 2011newletters. A link to the guidelines was also made available on the plan's Web site, and the provider newsletters included information on the Web site link.

Ohana

Ohana received recommendations to take actions to improve three of its validated HEDIS rates. A recommendation was made for any measure for which one or more indicator rates did not meet or exceed the HEDIS 50th percentile. For Ohana, this included:

- ***Comprehensive Diabetes Care***: Five indicators' rates were below the HEDIS 2009 Medicaid 50th percentiles: *LDL-C Control (<100 mg/dL), Eye Exam, Blood Pressure Control (<140/90 mm Hg), HbA1c Control (<7.0%)*, and *HbA1c Control (<8.0%)*. A sixth rate, the indicator for *HbA1c Poor Control (>9.0%)*, exceeded the 50th percentile; however, since this is an inverted measure, a lower rate indicates better performance. Therefore, these rates indicate opportunities for improvement.
- ***Ambulatory Care-ED Visits/1,000 Member Months***: The Total rate, as well as the rate for one age group, 1–9 Years, were above the HEDIS 2009 Medicaid 90th percentiles, indicating higher utilization, as this is an inverted measure. Increased or above-average utilization, particularly

ED use, is generally a negative outcome, and may indicate an opportunity for further assessment and improvement.

- ***Chlamydia Screening in Women***: Ohana fell below the HEDIS 2009 Medicaid 10th percentiles for all of the *CHL* indicators, *16–20 Years*, *21–24 Years*, and *Total*.

Ohana implemented the following improvement activities to address these measures:

Comprehensive Diabetes Care

1. Ohana's current Disease Management program includes educational coaching, reminders of annual testing, and information on community resources including support groups. Ohana planned to include a list of these diabetes support groups in member newsletters.

2. Ohana partnered with the Hawaii Tobacco Quitline for smoking cessation programs for members, including educational information, what to expect while quitting, free nicotine patches or gum, and coaching support calls.

3. Ohana has implemented several reminder systems for diabetes care. Periodicity letters outline the preventive health services that members should receive at certain ages. The letters are sent to newly enrolled members and those with the plan for 45 days that have not had a visit with their PCP. The letters are also sent annually to each member during their birthday month to remind them of the preventive services they may be due to receive based on their age. If these members have a diagnosis of asthma or diabetes, a statement is added to the letters to inform them to visit their PCP for follow-up, and in the case of the *Comprehensive Diabetes Care* measure—the screenings they should have. Over 7,000 letters have been mailed. Other reminder systems and interventions included:

   a. Identifying new diabetic members in a new member welcome call assessment:

      During the Health and Functional Assessment (HFA) process for all new members, as service coordinators (SCs) identify that a member is a diabetic, a flag is displayed recommending referral to Ohana's Disease Management (DM) program. The SC is then able to open up a DM program within EMMA (electronic medical record system) and the Disease Management staff will reach out to the member.

   b. Distributing health report cards to members with a testing and results history:

      Ohana recently created and piloted a database that identifies each member's care gap. The SC will be able to access the database prior to visiting with a member and identify which care gaps are still not met. The SC will use this information in counseling the member and assisting the member to set up appointments. The Disease Management staff will also use this tool when placing periodic calls to members to ensure that testing is completed and members are accessing their primary care physicians (PCPs).

      i. In September 2011, Ohana's Customer Service Department was provided a new ~~v~~view" within the CareConnects system. When a member calls the Customer Service Department for any reason, this module immediately shows the member's care gaps

and prompts the customer service representative (CSR) to assist members with appointments and reminders.

ii. Ohana worked with Diagnostic Lab Services (DLS) to obtain lab values for tests, including HbA1c and LDL-C tests in order to better capture members' lab results electronically, and to give the health plan more timely rates (results received quarterly).

iii. Providing incentives to members for compliance with all screening and testing requirements:

a) Ohana is exploring use of member incentive programs and awaiting preliminary results from other WellCare plans to see if improvement results from such initiatives.

b) Ohana implemented a Pay for Performance (P4P) incentive in early 2011 for providers with high volume members assigned (>100). Monetary incentives are provided for ensuring that the diabetic HEDIS measures are met for their member population.

iv. Distributing periodic newsletters with diabetes articles and updates

a) Member newsletter articles specific to diabetes care included:

i. Know the symptoms of diabetes
ii. See the value of annual eye exams
iii. Keep kids fit and healthy

b) Provider newsletter articles specific to diabetes care included:

i. Annual eye exams and glucometer use
ii. Diabetes care

v. Contacting noncompliant members using letters and/or telephone calls.

a) Ohana's Health Education Specialists access and use a database of members who are noncompliant and overdue for annual screenings and tests, provide educational coaching calls with members about overdue screenings and tests, and offer to assist members with appointments.

vi. Ohana has expanded its diabetes outreach into the community:

a) In February 2011, Ohana began a collaboration with a dozen not-for-profit health advocacy groups to provide on-site health screenings statewide. Two of the screenings were retinal screening and glucose testing.

b) In August, 2011, Ohana became a major sponsor of the American Diabetes Association's Living with Type 2 Diabetes Program. In addition to recommending Ohana's disease management programs, diabetic members are encouraged to join and participate in this free program.

Ambulatory Care—ED Visits/1000 Member Months

Ohana performed analysis of its utilization patterns, and identified areas for monitoring and improvement:

1. Travel utilization of neighbor islands—Ohana's UM department implemented a procedure to call a member's provider to ensure that an appointment was made prior to approval of travel. Service coordinators discussed transferring care to a local (on island) specialist if one was available. A decrease in overall neighbor island travel expenses was experienced after this medical expense initiative project.

2. ER utilization— Ohana's primary care physicians (PCPs) received quarterly emergency room (ER) Utilization Reports for their members with ER visits within a three-month rolling look-back period. The report included diagnosis, reason for visit, name of facility visited, and number of visits per member.

3. Provider relations representatives assigned to each PCP provided a face-to-face visit to deliver the ER Utilization Report as well as provide education on after-hour services available to members in lieu of receiving services from the ER, if appropriate. In addition, the representatives provide targeted education on a PCPs' obligation to have after-hours telephone services as stated in the following:
   a. PCP's must provide a 24-hour answering service;
   b. Answering system with option to page the physician; or
   c. An advice nurse with access to the PCP or on-call physician

4. Other provider initiatives included expanding access for after-hours visit accessibility statewide and creating incentive programs to reward PCPs who intervene to reduce ER visits.

5. Ohana reviewed the top diagnosis for ER utilization, discovered that a high number of return ER visits are due to behavioral health (BH) reasons and implemented a practice whereby high-utilizing BH members will be contacted by their SC to ensure that the member is connected to their PCP.

6. Ohana has partnered with The Queen's Medical Center to receive daily census data of members who have visited their ER within 24 hours. Through the service coordination model, members may receive a telephonic outreach to address areas such as the reason for the ER visit and if follow-up services are needed, whether successful PCP outreach was made or if the ER visit was during normal business hours.

7. Ohana identified a high number of ER admissions referred by one particular community case management agency (CCMA) and has initiated interventions to educate CCMAs regarding responsibilities for assessing members and engaging the member's PCP as opposed to an automatic referral to an ER.

Readmissions for same diagnosis within 31 days

1. Readmissions for same diagnosis have been reviewed quarterly by senior staff at Ohana, with congestive heart failure identified as one of the top reasons for readmission. A corporate WellCare physician-led team is working with the medical directors on a readmission project across the all WellCare entities.

2. Ohana is in discussions with its top hospitals to negotiate contractual changes that Ohana will not pay for readmissions if for the same diagnosis. These negotiations are still underway.

3. Ohana's Utilization Management Department established a pilot project with The Queen's Medical Center to work toward co-discharge planning, using on-site concurrent review nurses to also assist with the discharge planning of members that had frequent admissions or were difficult to discharge. Follow-up data to date showed a decrease in length of stay by early intervention and assistance.

Chlamydia Screening in Women

Ohana produced and sent several newsletter articles to members regarding women's health issues:

1. Schedule your preventive health visit.

2. Screenings for women's health.

Validation of Performance Improvement Projects

AlohaCare

Children's and Adolescents' Access to Primary Care

AlohaCare received the following recommendations for this validated PIP:

- Clearly reflect the plan's goal to increase the rate of ambulatory or preventive care visits in the study question, to include the applicable HEDIS technical specifications codes used in the study, and to document the year of the HEDIS specifications that were used.
- Document date ranges for each measurement period in all applicable review activities, and include further details about the quality improvement processes used in the development of the interventions.
- Conduct a second causal/barrier analysis to determine appropriate revisions to existing interventions or the implementation of new improvement strategies if the study indicators demonstrated a decline in performance.
- Perform data mining to gain further insights into the decline in performance, as well as to identify more effective improvement strategies.
- Consider tailoring interventions to target the 7–11-year-old and the 12–19-year-old age groups since the decline in performance for the related study indicators was statistically significant.

In response to the recommendations, AlohaCare implemented the following interventions:

1. PIP Documentation: AlohaCare has addressed the recommendations related to documentation of the PIP, including:
   - Clarifying the goal to increase the rate of ambulatory care/preventive visits in the study question.
   - Including the applicable HEDIS technical specifications codes used and the year of the technical specifications used in each phase of the study.
   - Documenting more clearly the date ranges for each measurement period.

2. Pay for Performance Incentives: In September 2009, AlohaCare launched a Quality Improvement Incentive Program (QIIP) for participating providers whereby providers could earn incentive payments for successfully completing quality improvement projects. This program continued in FY2011 with improving child and adolescent access to care as one of the options for eligible quality improvement projects.

3. Member Incentive Pilot: AlohaCare continued a pilot program it had launched in early 2010 to test the impact of a member incentive (a gift card) for completing recommended well-child visits and immunizations.

AlohaCare reported that additional barrier analysis and interventions to improve child and adolescent access to care will be initiated in 2011.

Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form

AlohaCare received the following recommendations for this validated PIP:

- Provide plan-specific information on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) documentation rates that supports the selection of the study topic, and document complete dates for the measurement periods.
- Include how actual rates compared to goals/benchmarks in the data analysis plan and in the interpretation of findings.
- Conduct a causal/barrier analysis on baseline results to evaluate current improvement strategies, such as the provision of BMI wheels to providers to identify their usefulness in documenting BMI and BMI percentiles, considering the low study indicator rates related to BMI documentation.
- Continue its efforts in developing community resources that address elevated BMI and educate providers on these available resources in order to improve the rates of documented referrals for elevated BMI percentiles.

In response to the recommendations, AlohaCare implemented the following interventions:

1. PIP Documentation: AlohaCare has addressed the recommendations related to documentation of the PIP, including documentation of initial rates to support the study topic, documenting complete dates for the measurement periods, and comparing actual rates to goals/benchmarks in the interpretation of findings.

2. Provider Education: The Winter 2010 issue of the provider newsletter provided an EPSDT Quick Reference Guide that provided information on early detection of overweight and obese children, calculating BMI, and additional resources for the online BMI calculator and charts. The Summer 2011 issue included an article, ~~–~~Hawaii 5-2-1-0 Let's Go!" which educated providers about the health plan and community collaboration for healthy children and families to combat overweight and obesity in children.

3. Community Resources: The Med-QUEST Division, the health plans, and the Nutrition and Physical Activity Coalition (NPAC) continue to work on developing an updated resource list for distribution to providers.

HMSA

Well-Child Visits in the First 15 Months of Life for QUEST Members

HMSA received the following recommendations for this validated PIP:

- Document corresponding interventions for all identified barriers to receiving well-child visits, and use the two-sided Chi-square test for statistical analysis based on the large population size.
- Perform a causal/barrier analysis on the baseline results to develop additional improvement strategies.
- Consider performing data mining to reveal further insights into the characteristics of the targeted population that may affect compliance with well-child visits.

In response to the recommendations, HMSA implemented the following interventions:

1. To promote the receipt of well-child visits in the first 15 months of life, mailed reminders were sent to parents of children that were at least eight months old with less than four well-child visits; and telephonic reminder calls were made to parents of children 12 months old with less than five well-child visits. The goal of the mailed and telephonic reminders centered on promoting the importance of well-child visits in an understandable way, informing parents that children do not need to be sick to go to the doctor, and providing plan contact information so members have a number to call if there are barriers to accessing care or if they have benefit-related questions.

2. In 2011, a Well Child Visits Quick Reference Guide (QRG) was created to assist providers and their office staff in achieving quality of care goals. The QRG is an office reference guide on the clinical measure for well-child visits for children turning 15 months and 3, 4, 5, and 6 years of age. It includes measure specification, CPT codes, and the recommended schedule from the American Academy of Pediatrics.

Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form

- Consistently document the age criteria defining the study population, and consider using the two-sided Chi-square test when performing statistical testing as the study progresses.
- Perform a causal/barrier analysis on the baseline results to identify additional barriers for which revised or additional interventions can be developed.
- Consider implementing additional provider-targeted interventions addressing BMI percentile documentation, such as the provision of BMI calculation tools to simplify the intensive process of BMI percentile calculation identified as a barrier in the PIP.
- Consider exploring community resources offered at no cost or minimal cost to members to potentially affect the currently low referral rates for obesity management.

In response to the recommendations, HMSA implemented the following interventions:

1. Print-based communications continued to be sent out in 2010 as a result of best practices discovered while researching childhood obesity, conducting focus groups with QUEST members, and communicating with providers and their staff about needs related to reducing the prevalence of childhood obesity and increasing resources related to the identification and treatment of overweight and obese children. The print-based communications aim to address the knowledge, attitudes, and behaviors of the target audience, which include parents of children and providers.

2. New EPSDT forms were launched in January 2010, and the Hawaii Initiative for Childhood Obesity Research and Education (HICORE), with which HMSA participates and supports, made significant efforts in educating providers and the community. With the new forms, documentation of BMI and BMI percentile became a requirement for enhanced EPSDT payment on April 1, 2010. This information on new requirements was distributed to the provider community via provider bulletin, contracts, and the provider handbook.

3. In April 2010, the American Academy of Pediatrics and HICORE sponsored a conference, with continuing education credits for pediatricians, on the topic of childhood obesity. At this conference, local and national leaders in the field of childhood obesity and pediatrics guided practitioners through identification and treatment of childhood overweight or obesity. Through HICORE, an initiative supported by all health plans including all QUEST health plans was also launched which will ensure common language is used among all health plans when addressing childhood obesity screening and care with their provider network and members.

Kaiser

Access to Care

Kaiser received the following recommendations for this validated PIP:

- Update the benchmarks and sampling information for remeasurement periods to provide complete and consistent date ranges for all measurement periods, to place the numeric values for the numerator and denominator of the study indicator in the data table in Activity IX, and to include additional details about the extent to which the PIP was successful.
- Conduct an additional causal/barrier analysis based on remeasurement results and revise current interventions or implement new improvement strategies as a decline in performance was demonstrated.
- Perform data mining to gain further insights into access-to-care barriers.
- Continue focused monitoring of selected measures and key processes to meet member needs and improve primary care access.

In response to the recommendations, Kaiser implemented the following interventions:

1. Addressed the technical documentation recommendations in the most recent submission of its Access to Care PIP. Although the numeric values for the numerator and denominator were

transposed in the resubmission, Kaiser will correct this in the next submission of documentation.

2. Continued to focus on improving primary care access using selected measures such as CAHPS and other select process measures monthly or quarterly as a priority as it relates to the overall service strategy.

Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form

Kaiser received the following recommendations for this validated PIP:

- Include complete timelines and goals for the measurement periods, and provide the barriers that the current interventions were developed to address.
- Perform a second causal/barrier analysis on baseline results to identify additional barriers, and develop interventions to specifically target the barriers identified.

In response to the recommendations, Kaiser implemented the following interventions:

1. Addressed the technical documentation recommendations (timelines, goals, and barriers) in the most recent submission of this PIP.

2. Identified that the counseling a physician provides on diet and physical activity during the office visit, along with the educational handouts, is comparable to a referral made to a dietician and should be counted and included in the related study indicator.

Evercare

Evercare received the following recommendations for its validated PIPs:

Diabetes Care

- Ensure that it adheres to the HEDIS technical specifications used in the study as it completes the study implementation phase of the PIP.
- Perform a causal/barrier analysis to identify specific barriers to obtaining diabetes screenings and develop appropriate improvement strategies.
- Consider initiating collaborations with community resources to strengthen efforts to improve screening rates for members with diabetes.

In response to the recommendations, Evercare implemented the following targeted interventions for improvement:

1. In 2011, HEDIS technical specifications were adhered to and hybrid measurement was conducted, according to HEDIS sampling specifications, to establish the initial baseline measurement for plan performance.

2. Initial barrier analyses were conducted in 2010, utilizing administrative data, and interventions were developed centering on provider and member education. In 2011, an additional barrier analysis was being conducted and interventions centering around diabetes disease management were implemented.

3. A universal tracking database (UTD) was developed to document outreach and to track interventions for preventive screening measures. A link between the Care Management documentation system and the UTD is being developed to facilitate timely, easy access to the UTD system, making information readily available to disease management and care management staff.

Assessing the Documentation of Body Mass Index (BMI)

- Ensure that its study implementation follows the HEDIS technical specifications chosen for its study indicators and study population, paying particular attention to the use of HEDIS-like specifications and documenting accordingly.
- Perform a causal/barrier analysis for developing and planning the implementation of improvement strategies that target identified barriers to BMI documentation.
- Consider ensuring that its documentation procedures for BMI include standardized forms and that their use is mandated for all providers to improve overall documentation rates.

In response to the recommendations, Evercare implemented the following targeted interventions for improvement:

1. In 2011, Evercare adhered to HEDIS technical specifications and conducted hybrid measurement, according to HEDIS sampling specifications, to establish the initial baseline measurement for plan performance.

2. Evercare conducted initial barrier analyses in 2010, utilizing administrative data, and developed interventions centering on provider and member education.

3. Evercare has determined, given the variety of electronic and paper records and systems in effect in the network, that for the child population the standardized EPSDT screening forms and BMI documentation are required and used; however, for adults, the plan does not mandate a single form for use by providers to document BMI. The plan is providing a BMI calculator for use by providers as part of the Provider Toolkit scheduled to be sent to PCPs and high-volume providers in mid-August.

Ohana

Ohana received the following recommendations for its validated PIPs:

Improving Comprehensive Diabetes Care

- Ensure that the documented HEDIS year for the study corresponds with the applicable measurement year.
- Ensure that a causal/barrier analysis is performed to develop interventions that specifically target the identified barriers to complying with standard diabetes care testing.
- Consider initiating collaborative efforts with community resources when developing improvement strategies, such as an educational campaign, diabetes clinic, or health fair.

In response to the recommendations, Ohana implemented the following targeted interventions for improvement:

1. Ohana implemented all of the documentation recommendations for the Diabetes PIP for the 2011 submission. The study year now corresponds with the applicable HEDIS year.

2. Causal/barrier analysis was conducted via fishbone diagram. Interventions were then tied to the analysis.

Improving Care for Members With Obesity

- Define the study indicators more completely and accurately to reflect the use of a hybrid data collection process in the PIP documentation and to provide rationale for the development of all study indicators.
- Define the study population in both the study indicators and in the study population definition consistently.
- Ensure that a causal/barrier analysis is performed to develop interventions to specifically target the barriers to reporting referrals to, and member attendance in, obesity management programs.
- Consider developing interventions targeting providers, including educating them on available obesity management programs and providing information on additional resources within the community.

In response to the recommendations, Ohana implemented the following targeted interventions for improvement:

1. Ohana addressed most of the documentation recommendations in the 2011 submission of the Obesity PIP. Hybrid data were not used in 2011, and the plan chose to change to administrative data only. The study population was identified.

2. Causal/barrier analysis was provided via fishbone diagram in the PIP submission. Interventions were then tied to the analysis.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey

QUEST Health Plans

Based on an evaluation of the statewide Adult CAHPS Survey results, the highest-priority measures identified for improvement for all the QUEST plans were *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. Methods suggested for improving these areas included:

Rating of Specialist Seen Most Often

- **Telemedicine**—Telemedicine models use electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities with a shortage of specialists.

- **Skills Training for Specialists**—Health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters.

- **Planned Visit Management**—By identifying patients with chronic conditions that have routine appointments, a system could be implemented to ensure that these patients have necessary tests before an appointment. Furthermore, follow-up with patients should be carried out to ensure that they understand all the information given to them during their visit.

Getting Care Quickly

- **Open Access Scheduling**—Open access scheduling models allow for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model involves leaving part of a physician's schedule open for same-day appointments

- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or a clinical service (i.e., the time it takes to complete various parts of the visit/service). This type of analysis can help providers identify problem areas and where unnecessary steps can be eliminated or steps can be performed more efficiently.

AlohaCare

AlohaCare responded to the recommendations by implementing the following strategies:

1. Patient-Centered Health Care Home (PCHCH) Pilot: AlohaCare has been an active participant with the Hawaii Primary Care Association to implement a model of the PCHCH in Hawaii. A key objective of this pilot is redesign of primary care delivery processes at the pilot sites to improve patient access to primary care. Evaluation of this pilot will continue through 2011 and expansion plans to 10 additional sites are in progress.

2. Provider Education: To reinforce AlohaCare's access and availability standards, the health plan included an article in the Summer 2011 provider newsletter which reviewed AlohaCare's guidelines for out of office protocol.

3. AlohaCare's Access and Availability Funding Program: Because the shortage of primary care and specialty providers, particularly on neighbor islands, creates barriers to access to care for AlohaCare members, AlohaCare's Board of Directors has allocated $300,000 in each of the past three years to support recruitment and retention of providers. In 2010 these funds were used by:
   - Bay Clinic, Inc., to recruit two behavioral health providers and two primary care physicians.
   - Hamakua Health Center to recruit a primary care physician and a behavioral health provider.
   - Maui Memorial Medical Center to recruit an APRN-Rx.
   - Hawaii Island Family Health Center to recruit a primary care physician.
   - Molokai Community Health Center to recruit a family practice physician and a pediatrician.

HMSA

HMSA responded to the recommendations by implementing the following strategies:

1. HMSA QUEST has a telemedicine policy in place that encourages the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data, using interactive audio, video or data communications. Covered services and coding and billing instructions for telemedicine are included in the provider handbook which is accessible to all participating providers.
2. HMSA is exploring ways in which its Online Care can be made available to QUEST members. HMSA's Online Care is a health care service that would allow HMSA QUEST members to interact with their physician or another HMSA participating physician or specialist via the World Wide Web or telephone at any time day or night. HMSA's Online Care is convenient, easy to use, and sessions are quick, secure, and private. Discussions with Med-QUEST continue as the health plan looks into how HMSA's Online Care could be integrated into the existing care delivery model.
3. HMSA is currently developing a Web-based electronic referral and authorization system for PCPs and specialists. The system will allow providers to submit referrals and authorizations, verify if a referral was submitted, or check on the status of an authorization. The system is scheduled to be available in early 2012.

Kaiser

Kaiser responded to the recommendations by implementing the following strategy:

Kaiser continued to focus on improving service as it relates to member satisfaction. The region recently formed a service council in 2011 accountable for monitoring all aspects of service and member satisfaction-related data and recommending improvement strategies. Kaiser reported that it has processes in place to address all of the recommendations.

QExA Health Plans

Based on an evaluation of the statewide Adult CAHPS Survey results, the highest-priority measures identified for improvement for the QExA plans were *Rating of Health Plan* and *Customer Service.* Methods suggested for improving these areas included:

Rating of Health Plan

- **Health Plan Operations**—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services) for members that provide the health plan's health care ~~–p~~roducts." A microsystems approach focuses on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

- **Health Plan Experiences**—Health Plan Experiences—Quality initiative efforts should focus on the member's overall experience with the health plan. This includes effectively managing paperwork to ensure a complete and timely process. It is also important for health plans to monitor the relevance and comprehensiveness of information distributed to its members. Furthermore, providing high-quality customer service can help improve members' perceptions of their health plan.

Customer Service

- **Tools to Further Identify Challenges**—Health plans can create an individualized survey based on key areas that are noted for improvement and develop questions that will identify specific challenges that need to be addressed. Furthermore, a focus group can provide insight into additional problems that cannot be captured through a survey.

- **Service Recovery**—A health plan can implement a service recovery program to ensure that members are provided appropriate attention in dealing with their problems. Service recovery can include listening to a patient who is upset, handing out incentives to patients who have had to wait longer than a specified time for a doctor visit, and assessing the events to identify the source of the problem.

- **Customer Service Performance Measures**—Setting plan-level customer service standards can assist in addressing issues and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

- **Employee Training and Empowerment**—It is important for health plans and providers to ensure that customer service staff have adequate training on all pertinent business processes. In addition, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to various employees and will help to bring timely resolution to a complaint.

- **Call Centers**—An evaluation of current call center hours and practices can be conducted to determine if the hours and resources meet member needs. Additionally, members can be asked at the end of a call to complete a short survey, which can be used to determine if members are getting the help they need and identify areas for improvement.

Evercare

Evercare responded to the recommendations by implementing the following targeted strategies:

1. Increased review of grievances at a detail level:
   a. Consistent hand-off and follow-up of improvement opportunities as identified via individual grievances (Examples: wait time, provider access, earlier attainment of AOR/POA).
   b. Additional communication to members regarding nonemergent transportation guidelines.
   c. Additional communication to dual members and providers on pharmacy benefit coordination to minimize confusion with multiple drug coverage.
   d. A one-week quality training session for customer service representatives.
   e. Motivational interview training for all staff with direct member contact to enable front-line staff to better understand, empathize and communicate with members to effectively resolve member issues.
   f. Insourced and transitioned all telephonic utilization review, medical management and intake functions from MDX-Hawaii to Evercare QExA in January 2011 to allow for better control and monitoring of processes and procedures. The transition resulted in:
      i. Improved turnaround-time for HCBS UM decision-making
      ii. Revision of the transportation request form at the request of providers
      iii. Improved communication of UM decisions to include providers and agencies
      iv. Clarification of verbiage in denial letters to members to make the reason for denial more easily understood by members
      v. Addition of six RN clinical staff to serve non-nursing home LOC members
      vi. Additional risk-stratification of membership, assigning highest risk members to RNs
      vii. Improved direct telephonic access to service coordinators by providers
      viii. Change in the ID for outgoing calls to read as a local caller
   g. Call center metrics, including average speed to answer, abandonment rate and average handle time are tracked and monitored at least monthly and reported quarterly to the plan's Service Quality Improvement Committee. Thresholds for performance are established based on NCQA and State contract requirements.
   h. Call center quality metrics are audited and monitored based on benchmarks, and interventions are discussed and implemented as needed to improve attainment of goals. Metrics include:
      i. First call resolution

ii. Phone technique
iii. Accuracy of response
iv. Building trust

i. Developed a three-tiered provider structure which increases the face-to-face interaction with providers.
j. Implemented provider service metrics which are reviewed at the MDX / EVC Joint Operations Committee and the Service Quality Improvement Committee.
k. Provided one week of quality training to the customer service representatives and provided compliance training to call center staff with a focus on member/provider grievances and HIPAA compliance.
l. Conducted motivational interview training for all staff with direct member contact to enable front-line staff to effectively resolve issues.
m. Developed a Field Process Improvement Team empowered to analyze member and process needs in the field and initiate change to resolve issues
n. Adopted the ~~–~~Building Community" initiative that includes:
   i. Cultural training for staff
      - Act with integrity
      - Look for innovation
      - Work with compassion
      - Seek better performance
      - Build stronger relationships
   ii. Leading Change training for the management team
o. Increased the number of Customer Service Call Center agents dedicated to QExA.
p. Revised the department staffing schedules to ensure adequate phone coverage for QExA.
q. Increased CSR phone ring volume when low phone ring volumes were identified as a possible cause to the dip in service levels.
r. Talking points developed for CSRs whenever a large plan initiative is expected (e.g., July 1 change in transportation benefit, CAG conversions, etc.)
s. An analysis of call center personnel attrition is being conducted.

Ohana

Ohana responded to the recommendations by implementing the following targeted strategies:

1. Developed new positions within the company of vice president, provider experience, and vice president, member experience. These leaders are tasked with mapping all interactions that members and providers have with the health plan, and identifying and deploying the most relevant process improvements.

2. Established a Quality Improvement Interventions Workgroup (QIIW) to focus on the findings from the 2010 CAHPS survey.

3. Conducted a full review of the Member Handbook, and updated the content to improve member understanding of benefits, health plan processes, and methods to obtain care. Identified areas where there were high volume of complaints/grievances and ensured that language was expanded in Member Handbook in those areas.

4. Established and implemented a Member Advisory Committee to provide direct member input to plan operations. One of the recommendations resulting from this Committee was to make the member newsletters more user-friendly and ~~l~~local."

5. Analyzed and trended the top complaints for 2010 and identified transportation. Ohana has selected and contracted with a new vendor to provide and manage transportation services.

6. Established a taskforce of the QIIW (the Web Improvement Work Group), which has identified and implemented several key improvements in the functionality and performance of the ohanahealthplan.com Web site for both members and providers.

7. Implemented and rolled out CareConnects, a new agent desktop, that provides a guided call experience that should help to improve the quality of each call. Random calls are audited by a manager to ensure consistency and application of the new product in order to continue coaching the representatives.

8. Implemented a CSAT (Customer Satisfaction Survey) on March 19, 2011, which is offered on all calls. If the caller opts to take the survey, he or she will receive a call shortly after the initial call with the customer service representative. This allows the caller to provide immediate feedback. The health plan uses this data to identify and implement process improvements throughout the organization.

9. Conducted regular refresher trainings on claims so that the customer service representatives gain confidence and are empowered to resolve most issues for providers. In addition to this ongoing training, all Ohana Health Plan representatives who have contact with members and/or providers receive annual training on complaint and grievance handling.

10. Ohana's grievance process ensures that members are provided appropriate assistance and resolution for their problems, and that corrective action is taken to prevent repeat issues.

11. Service recovery was added to the agenda for the monthly Customer Service Quality Improvement Workgroup.

12. Ohana conducted a Utilization Management (UM) Satisfaction survey with random members asking about issues regarding responses to authorization requests, timeliness of authorization requests, etc.

13. Ohana evaluated customer service performance measures monthly during operational meetings to ensure that required time frames are met, and performed root cause analysis when measures were met to identify opportunities for improvement.

Appendix A. Methodologies for Conducting EQR Activities

During 2011, HSAG, as the EQRO for the MQD, conducted the following EQR activities for the QUEST and QExA health plans in accordance with applicable CMS protocols:

- A review of compliance with federal and State requirements for select Quality Assessment and Performance Improvement (QAPI) standard areas
- Validation of performance measures (i.e., HEDIS compliance audits)
- Validation of PIPs
- A survey of child/adolescent enrollees using the Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- A survey of providers using a customized instrument for PCPs and specialists providing Medicaid services for the QUEST and QExA health plans

For each EQR activity conducted in 2011, this appendix presents the following information, as required by 42 CFR 438.364:

- Objectives
- Technical methods of data collection and analysis
- Descriptions of data obtained

Compliance Monitoring Review

Objectives

The BBA, as set forth in 42 CFR 438.358, requires that a state or its designee conduct a review to determine each MCO's and PIHP's compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To complete this requirement, HSAG—through its EQRO contract with the MQD—conducted a compliance evaluation of the QUEST and QExA health plans. For the 2011 EQR compliance monitoring activity, HSAG conducted a desk audit and an on-site review of each of the health plans to assess compliance with select federal managed care regulations, as contained in the health plans' contracts with the MQD. QAPI standards from Subpart D of the federal managed care regulations at 42 CFR 438 for structure and operations were selected for this review. The primary objective of HSAG's 2011 review was to provide meaningful information to the MQD and the QUEST and QExA health plans regarding contract compliance, as well as strengths and areas for improvement for each health plan.

The following five standards were assessed for health plan compliance:

- Standard I Delegation
- Standard II Member Information
- Standard III Grievance System
- Standard IV Provider Selection
- Standard V Credentialing

The findings from the desk audits and the on-site reviews were intended to provide the MQD and each health plan an assessment to be used to:

- Evaluate the quality and timeliness of, and access to, care furnished by the health plan.
- Identify, implement, and monitor interventions needed for improvement.
- Evaluate the plan's current structure, operations, and performance on key processes.
- Initiate targeted activities to ensure compliance or enhance current performance, as needed.
- Plan and provide technical assistance in areas noted to have substandard performance.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring reviews, HSAG, in collaboration with the MQD, developed a standardized data collection tool to use in the review. The content of the tool was based on applicable federal and State laws and regulations, the Hawaii QUEST Request for Proposal (issued June 14, 2006) as amended, and the QUEST Expanded Access Request for Proposal (issued October 10, 2007) as amended.

HSAG conducted the compliance monitoring review in accordance with the CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. HSAG performed the same set of required activities as described in the above protocol for each health plan:

- Planning for compliance monitoring activities
- Obtaining background information from the MQD
- Conducting a document review
- Conducting interviews
- Collecting any other accessory information (e.g., from site visits)
- Analyzing and compiling findings
- Reporting results to the MQD and the QUEST and QExA health plans via the preparation of individual, health plan-specific compliance monitoring reports

For the 2011 review, HSAG staff assigned an aggregate compliance score for each of the five standards. Each element within each standard was scored using a numerical rating. A scoring system of *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* or *Not Scored* (value: 0.00 points) was used. The totals for points received out of all applicable points were used to calculate each health plan's overall score for each of the standards. A percentage was also determined for a combined overall rating across all standards. By contract, the MQD required the QUEST and QExA health plans to submit a corrective action plan (CAP) for any standards that resulted in a final score below 100 percent.

Description of Data Obtained

To assess the health plans' compliance with federal and State requirements for this compliance monitoring review, HSAG obtained information from a wide range of written documents, including committee meeting agendas, minutes, and handouts; policies and procedures; reports; and member and provider handbooks. For the record reviews, HSAG generated audit samples based on data files that the health plans provided (i.e., listings of member appeals, member grievances, and provider credentialing and recredentialing records). HSAG also obtained information for the compliance monitoring review through observation during the on-site review and through interaction, discussion, and interviews with key health plan staff members.

The major data sources HSAG used to determine compliance with requirements were documents submitted by the health plans for HSAG's desk audit and those presented during the on-site review, member appeal records, member grievance records, provider credentialing and recredentialing records, and additional information obtained from on-site interviews. The time period to which the record/file reviews applied was March 1, 2010 to February 28, 2011. Similarly, the time period to which the documentation and interview information applied was March 1, 2010, through the dates of the health plan's on-site review (conducted during late April and early May 2011). Following the compliance reviews, HSAG provided each health plan with a report of findings and required

corrective actions. The plan-specific results are summarized in Section 3 of this report, and in Section 4 a statewide comparison of all plan results is provided.

Validation of Performance Measures—HEDIS Compliance Audits

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the State-selected HEDIS measures for the 2011 validation activities.

Table A-1—2011 Validated HEDIS Measures	
Validated HEDIS Measure	**HEDIS Abbreviation**
Childhood Immunization Status	*CIS*
Comprehensive Diabetes Care	*CDC*
Ambulatory Care	*AMB*
Cholesterol Management for Patients With Cardiovascular Conditions	*CMC*
Breast Cancer Screening	*BCS*
Chlamydia Screening in Women	*CHL*

Technical Methods of Data Collection and Analysis

HSAG conducted the validation of the QUEST and QExA health plans' HEDIS measures using selected methodologies presented in the *2011 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5*. The measurement period reviewed for the QUEST and QExA health plans was concurrent (CY 2010) and followed the NCQA HEDIS timeline for reporting rates.

The same process was followed for each performance measure validation conducted by HSAG and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap); and (2) on-site activities such as interviews with staff members, primary source verification, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the QUEST and QExA health plans' IS capabilities for accurate reporting. The review team focused specifically on aspects of the health plans' systems that could impact the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; the use of supplemental data sources; and data integration and measure calculation. If an area of noncompliance was noted with any IS standard, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

Each HEDIS measure verified by the HSAG review team for the QUEST and QExA health plans received an audit result consistent with one of the four NCQA categories listed in the following table.

Table A-2—NCQA Audit Results

NCQA Category for Measure Audit Result	Meaning
R = Report	Reportable rate or numeric result for HEDIS measures.
NA = Not Applicable	Small denominator: The organization followed the specifications but the denominator was too small to report a valid rate.
NB = No Benefit	The organization did not offer the health benefits required by the measure.
NR = Not Report	1. The plan chose not to report. 2. The calculated rate was materially biased. 3. The plan was not required to report.

For the purposes of comparison and assessment of improvement over time, HSAG used the Pearson's Chi-square (X^2) test to examine whether statistically significant differences between HEDIS 2010 (CY 2009) rates and HEDIS 2011 (CY 2010) rates existed. A difference was considered statistically significant if the *p* value was less than 0.05. Statistical significance testing was only performed on measures where rates are presented as a percentage. Trend analysis will not report any significant testing results for measures using per 1,000 member months (e.g., *Ambulatory Care*) as reporting units. Measures with statistically significant improvement were denoted in green showing the magnitude of the percentage point differences. Similarly, measures with statistically significant decline were denoted in red. For inverse measures (e.g., *Comprehensive Diabetes Care—HbA1c Poor Control*), a statistically significant decline was shown in red with positive percentage point differences. Conversely, a statistically significant improvement was shown in green with negative percentage point differences. Measures for which there was no statistically significant change were shown with the percentage point increase or decrease in black.

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

- Completed responses to the HEDIS Roadmap published by NCQA as Appendix 2 to the *2011 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5* for the health plans.
- Source code, computer programming, and query language (if applicable) used by the health plans to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors for the health plans.

Information was also obtained through interaction, discussion, and formal interviews with key staff members, as well as through system demonstrations and data processing observations.

After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for the MQD and each QUEST and QExA health plan. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.

Validation of Performance Improvement Projects

Objectives

As part of the State's quality strategy, each QUEST and QExA health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.240. The purpose of these PIPs was to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical care and services and in nonclinical areas. As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated the PIPs through an independent review process that followed the CMS protocol. The primary objective of the PIP validation was to determine compliance with requirements set forth in 42 CFR 438.240, including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

In 2011, HSAG performed the validation activities on a total of 10 PIPs submitted by the Hawaii Medicaid health plans, as described in the following table:

Table A-3—2011 Validated PIPs

Health Plan	PIP Topic
AlohaCare	1. *Access to Care* 2. *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form*
HMSA	1. *Access to Care* 2. *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form*
Kaiser	1. *Access to Care* 2. *Assessing the Documentation of Body Mass Index (BMI) or Height and Weight Using the EPSDT Form*
Evercare	1. *Diabetes Care* 2. *Assessing the Documentation of Body Mass Index (BMI)*
Ohana	1. *Diabetes Care* 2. *Improving Care for Members With Obesity*

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting PIPs, HSAG also identified that the QUEST and QExA health plans' PIPs contained study indicators related to the quality, access, and timeliness domains. More specifically, all 10 PIPs provided opportunities for the health plans to improve the quality of care for its members. The *Access to Care* PIP study indicators were also designed to improve members'

access to care and services for targeted populations, such as well-child visits for children and adolescents.

Technical Methods of Data Collection and Analysis

The methodology HSAG used to validate the PIPs was based on the CMS protocol as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002*.

HSAG, in collaboration with the MQD, developed the PIP Summary Form to be consistent with CMS' established protocols for conducting PIPs and to assist the QUEST and QExA health plans in meeting compliance requirements. The health plans were provided the PIP Summary Form to complete and submit to HSAG for review.

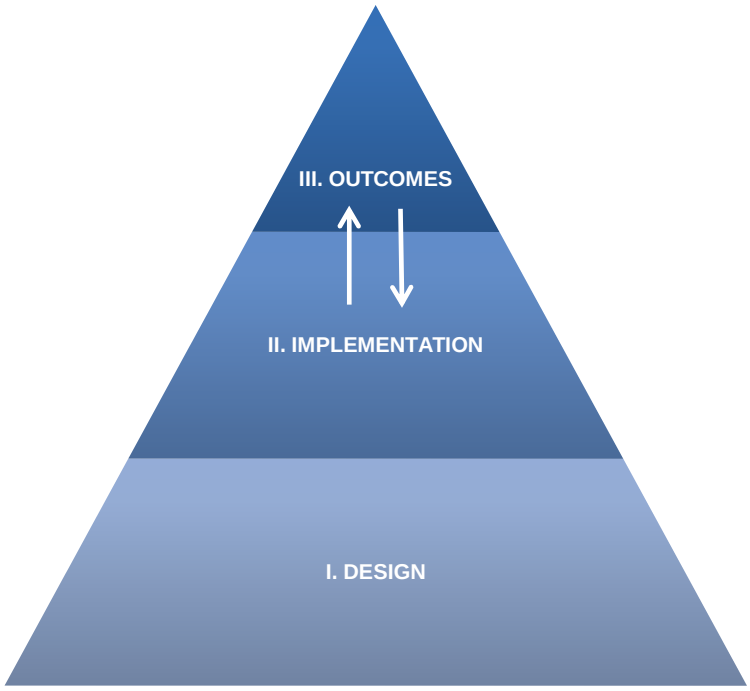
HSAG obtained the data needed to conduct the PIP validation from the health plan's PIP Summary Forms. These forms provided detailed information about each health plan's PIPs related to the activities they completed and HSAG evaluated for the 2011 validation cycle.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A health plan would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure A–1 illustrates the three study stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study topic, question, indicators, and population. To implement successful improvement strategies, a strong study design is necessary.

Figure A–1—PIP Study Stages



Once the health plan establishes its study design, the PIP process moves into the Implementation stage. This stage includes data collection, sampling, and interventions. During this stage, the health plan collects measurement data, evaluates and identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The final stage is Outcomes, which involves data analysis and the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. If the study outcomes do not improve, the health plan investigates the data collected to ensure that it has correctly identified the barriers and implemented appropriate and effective interventions. If it has not, the health plan revises the interventions and collects additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained statistical improvement is achieved.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

Objective

The primary objective of the Child CAHPS survey was to effectively and efficiently obtain information on the levels of satisfaction of the parents/caretakers of Hawaii Medicaid child/adolescent members with their child's health plan and health care experiences.

Technical Methods of Data Collection and Analysis

Data collection was accomplished through the administration of the CAHPS 4.0H Child Medicaid Health Plan Survey to the parents/guardians of child and adolescent Medicaid members of the QUEST and QExA health plans. Members selected for the survey were under the age of 18. The participating QUEST plans included AlohaCare, HMSA, and Kaiser. The participating QExA plans included Evercare and Ohana.

The CAHPS survey included a set of standardized items (47 questions) that assessed parents'/guardians' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their health plan, health care, personal doctors, and specialists. The composite scores were derived from sets of questions to address different aspects of care (e.g., Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was designated as *Not Applicable (NA).*

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite questions' response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always," or (2) "Definitely

No," "Somewhat No," "Somewhat Yes," and "Definitely Yes." A positive or top-box response for the composites was defined as a response of "Always" or "Definitely Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures.

In addition to the global proportions, a three-point mean was calculated for each of the composite measures. Scoring was based on a three-point scale. Responses of "Always" and "Definitely Yes" were given a score of 3, responses of "Usually" and "Somewhat Yes" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

The resulting three-point mean scores were compared to NCQA's 2011 HEDIS Benchmarks and Thresholds for Accreditation, except for the Shared Decision Making composite.[A-1, A-2] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star ratings were based on NCQA's 2010 National Child Medicaid data.[A-3, A-4] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile
NA	indicates that the health plan did not meet the minimum NCQA reporting threshold of 100 respondents

Additionally, HSAG performed a trend analysis of participating QUEST health plans' results.[A-5] Each QUEST health plan's 2011 CAHPS scores were compared to their corresponding 2009 CAHPS scores to determine whether there were statistically significant differences.[A-6] This comparison was performed on the four global ratings and five composite measures.

The 2011 Child CAHPS survey results for the QExA health plans provide an initial baseline assessment of parents/caretakers satisfaction with their child's/adolescent's health plan, Evercare or Ohana. Therefore, caution should be exercised when interpreting results.

[A-1] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2011*. Washington, DC: NCQA, January 31, 2011.
[A-2] 2011 represents the first year NCQA HEDIS Benchmarks and Thresholds for Accreditation were released for the child Medicaid population.
[A-3] NCQA National Distribution of 2010 Child Medicaid Plan-Level Results. Prepared by NCQA for HSAG on November 23, 2010.
[A-4] The star assignments for the Shared Decision Making composite were determined by comparing each of the health plans' three-point mean scores to the distribution of NCQA's 2010 National Child Medicaid data.
[A-5] 2011 represents the first year the QExA health plans were surveyed; therefore, trending could not be performed.
[A-6] The child population was not surveyed by HSAG in 2010.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics that are important to members, such as the communication skills of providers and the accessibility of services. The survey was administered from February to May 2011 and was designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the CAHPS survey, HSAG provided each health plan and the MQD with a plan-specific report of findings, and a statewide aggregate report was provided to the MQD. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.

Provider Survey

Objective

The objective of the Provider Survey was to provide feedback to the MQD and the health plans about providers' perceptions of the QUEST and QExA health plans and the Med-QUEST program.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the 2011 Hawaii Provider Survey to a random sample of 1,500 providers: 400 Kaiser providers and 1,100 non-Kaiser (i.e., AlohaCare, Evercare, HMSA, and/or Ohana) providers. Providers eligible for sampling included those who serve the Hawaii Medicaid population and contracted with at least one of the QUEST or QExA plans. The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the Web-based survey by logging on to the survey Web site with a designated provider-specific login. The survey was administered from April to June 2011 and included 23 questions that surveyed providers on a broad range of topics.

Results were determined within six domains of satisfaction: General Positions, Health Plan Communication, Formulary, Specialists, Providing Quality Care, and Behavioral Health. Response options to each question within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied. For each question, the percentage of respondents in each of the response categories was calculated. Health plan survey responses were limited to those providers that indicated they had a contract with that health plan in Question 3 of the survey. For example, if a provider indicated that he/she did not have a current contract with AlohaCare in Question 3, his/her responses would not be included in the results pertaining to AlohaCare, if a response had been provided. Therefore, providers may not have rated every health plan on every survey question. Furthermore, if a provider was associated with more than one health plan, he/she may have answered a question for multiple health plans.

Standard tests of statistical significance were conducted, where applicable, to determine if statistically significant differences in performance across health plans existed. As is standard in most survey implementations, a "top-box" rate was defined by a positive or satisfied response.

Furthermore, HSAG performed a trend analysis of participating QUEST health plans' results.[A-7] Each QUEST health plan's 2011 Provider Survey results were compared to their corresponding

[A-7] 2011 represents the first year providers were surveyed regarding the QExA health plans; therefore, trending could not be performed.

2009 Provider Survey results, where applicable, to determine whether there were statistically significant differences.[A-8]

The 2011 Hawaii Provider Survey results for the QExA health plans provide an initial baseline assessment of contracted providers' satisfaction with Evercare and Ohana; therefore, caution should be exercised when interpreting results.

Description of Data Obtained

The survey covered topics for primary care and specialty providers including the impact of plans' utilization management on the providers' ability to provide quality care, reimbursement satisfaction, and adequacy of formulary. The response rate was the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire random sample minus ineligible providers, which included any provider that could not be surveyed due to incorrect or incomplete contact information or that had no current contract with any of the health plans.

Following the administration of the provider survey, HSAG provided the MQD with an aggregate report of plan-specific findings. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.

[A-8] The Provider Survey was not administered in 2010.

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, hereby certify that

HEALTH SERVICES ADVISORY GROUP, INC.

Control Number: 99THT

a corporation formed under the laws of Arizona has filed its "Application for Certificate of Authority" to transact business in West Virginia as required by the provisions of the West Virginia Code. I hereby declare the organization to be registered as a foreign corporation from its effective date of February 27, 2012.

Therefore, I issue this

CERTIFICATE OF AUTHORITY

to the corporation authorizing it to transact business in West Virginia

Given under my hand and the Great Seal of the State of West Virginia on this day of February 27, 2012

Natalie E Tennant

Secretary of State

(H)

FILED

FEB 27 2012

IN THE OFFICE OF SECRETARY OF STATE

Natalie E. Tennant
Secretary of State
1900 Kanawha Blvd E.
Bldg 1, Suite 157-K
Charleston, WV 25305

Penney Barker, Manager
Corporations Division
Tel: (304)558-8000
Fax: (304)558-8381
www.wvsos.com
M-F 8:30 a.m. – 5:00 p.m. ET

FILE ONE ORIGINAL
(Two if you want a filed stamped copy returned to you)
FEE: $100.00 for profit
$50.00 non-profit

CERTIFICATE OF AUTHORITY

Control # 99THT

1. **Home State Information:**

   a. The name of the corporation as it is registered in its home state is: Health Services Advisory Group, Inc.

   b. State of AZ Date of Incorp: 8/18/1982 Duration (no. yrs or perpetual) Perpetual

   c. NAIC# (if an insurance company) _____

2. **Principal Office Information:**

   a. Address of the principal office of the corporation:
   No. & Street: 3133 E Camelback Rd #300
   City/State/Zip: Phoenix AZ 85016

   b. Mailing address, if different, from above address:
   Street/PO Box: _____
   City/State/Zip: _____

3. **West Virginia Information:**

   a. Corporate name to be used in W. Va.: Check one
   (Note, you may only select DBA if your name is not available for use in WV.)
   ☑ Home state name as listed on line 1.a above, if available
   ☐ DBA Name: _____

   b. Address of registered office in West Virginia if any:
   No. & Street: _____
   City/State/Zip: _____

   c. Mailing address in WV, if different from above:
   Street/PO Box: _____
   City/State/Zip: _____

4. **Agent of Process:**
   Properly designated person to whom notice of process may be sent, if any:
   Name: National Corporate Research, Ltd.
   Address: 1627 Quarrier Street East
   City/State/Zip: Charleston WV 25311

5. **Proposed purpose(s) for transaction of business in West Virginia is:**

   Healthcare Consulting

6. **E-mail address where future correspondence can be received:** ksanchez@hsag.com

7. **Corporate Status Information:**

   a. Corporation is organized as (check one): ☑ For Profit ☐ Non-Profit

   b. Directors and Officers: (add extra page if necessary; please list all officers)

Officer	Name	Address
President	Mary Ellen Dalton	3133 E Camelback Rd #300, Phoenix, AZ 85016
Treasurer/Vice President	Joellen Tenison	3133 E Camelback Rd #300, Phoenix, AZ 85016
Director	Bruce Bethancourt	3133 E Camelback Rd #300, Phoenix, AZ 85016
Director	Len Kirschner	3133 E Camelback Rd #300, Phoenix, AZ 85016
Director	Walter Nieri	3133 E Camelback Rd #300, Phoenix, AZ 85016

8. **The number of acres of land it holds or expects to hold in West Virginia is:** 0

9. **Contact and Signature Information:**

   a. Kerri Sanchez (Contact Name) — 602.801.6630 (Phone Number)

   b. Joellen Tenison (Print or type name of signer) — Vice President/Treasurer (Title / Capacity of Signer)

   c. Joellen Tenison (Signature) — 2/23/2012 (Date)

STATE OF ARIZONA

Office of the
CORPORATION COMMISSION

CERTIFICATE OF GOOD STANDING

To all to whom these presents shall come, greeting:

I, Ernest G. Johnson, Executive Director of the Arizona Corporation Commission, do hereby certify that

HEALTH SERVICES ADVISORY GROUP, INC.

a domestic corporation organized under the laws of the State of Arizona, did incorporate on August 18, 1982.

I further certify that according to the records of the Arizona Corporation Commission, as of the date set forth hereunder, the said corporation is not administratively dissolved for failure to comply with the provisions of the Arizona Business Corporation Act; and that its most recent Annual Report, subject to the provisions of A.R.S. sections 10-122, 10-123, 10-125 & 10-1622, has been delivered to the Arizona Corporation Commission for filing; and that the said corporation has not filed Articles of Dissolution as of the date of this certificate.

This certificate relates only to the legal existence of the above named entity as of the date issued. This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's condition or business activities and practices.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Arizona Corporation Commission. Done at Phoenix, the Capital, this 17th Day of February, 2012, A. D.

SEAL OF THE ARIZONA CORPORATION COMMISSION
DITAT DEUS
1912

Executive Director

By: