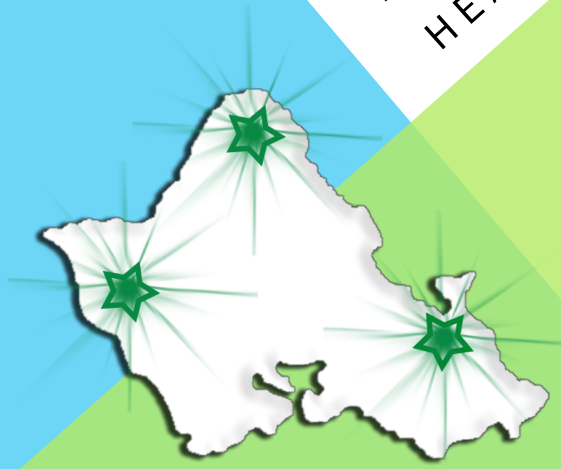
HEALTH PLAN 360 EVALUATION TEMPLATE

HEALTH PLAN PROFICIENCIES TO BE EVALUATED



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ELEMENT A: Basic Data Requirements

- Plan describes data definitions and plan for extraction for all outcome and process measures.
- Plan delivers data on a quarterly basis.
- Plan meets quarterly with clinic Quality Improvement managers.

ELEMENT B:
Specialty Network – Accepting New Patients

- Plan has an adequate specialty care network of providers so that 95% of enrollees have a specialty care provider within 20 miles of their residence.
- Plan maintains a list of specialists that is accurate, specific to QUEST patients, and updated monthly.
- Plan provides a dashboard/database of 3rd next available appointment with specialists.
- Plan assumes ultimate responsibility of finding specialty care for patients when deemed necessary by their PCP and has a system in place for addressing remedial action indicated by the data.
- Plan strives to support integration of primary care and behavioral health services by making available behavioral health services within 10 miles of the primary care provider's office and within 24 hours from the time of referral.

ELEMENT C: Claims Processing

- Plan provides eligibility data through online lookup and 270/271 format.
- Plan accepts 837P and 837I electronic claims at no cost to provider.
- Plan accepts claim attachments such as EPSDT forms and progress notes electronically.
- Plan provides 835 electronic remittance (no more than 1 per day) and image of paper remittance advice electronically.
- Plan performs automatic coordination of benefits from Medicare, plan's other line of businesses, and other major payers in Hawaii.
- Plan provides online tool of denial appeal with tracking and timely response (within 30 days).

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ELEMENT D: HIT and Care Coordination

- Plan implements electronic, near real-time and secure bidirectional, information exchange between providers and the plan for enrollment, eligibility and clinical data, in addition to claims.
- Plan supports a collaborative effort in development and implementation of an electronic care management system, including advanced registry tools to identify and track patient populations, patients with specific or co-morbid conditions, not recently seen, missed appointments, recently discharged, medications, identification of patient cohorts by providers or care teams, and the use of predictive analytics.

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- Plan uses modern interface standards (HL7-CCR, and CCD) for exchanging data.
- Plan provides online access to risk-pool data (capitation, PPS, and other financial measures).
- Plan implements electronic submission of EPSDT data.
- Plan provides support for implementation and investment in personal health records, secure electronic messaging, mobile care management technologies and home health monitoring devices.
- Plan provides support for a patient portal for appointments, pharmacy refills, emailing documents and accessing health record and supports patient education on the use of these tools.

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ELEMENT E: Value Added Services Support for Health Care Home Model

- Plan provides support for advanced care enabling services as defined by the association of Asian Pacific Community Health Organizations (AAPCHO).
- Plan provides support for medical nutrition therapy for patients at risk for hypertension, diabetes, and related conditions.
- Plan provides support for eligibility assistance and other financial counseling useful to the patients in maintaining QUEST eligibility.
- Plan provides support for services to CSAC certified substance abuse counselors for patients diagnosed with substance abuse issues.

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- Plan provides support for exercise program for patients at risk for hypertension, diabetes and related conditions.
- Plan provides support for services of traditional practitioners certified under a recognized Kupuna Council.
- Plan provides support for community involvement in health care home efforts with community to facilitate behavior change at a population level.
- Plan provides support for compliance with NCQA Patient Centered Medical Home (PCMH) and Meaningful Use (MU) standards; in addition to supplemental PCMH standards for MUA/MUP populations.

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ELEMENT F: Aligned Incentives and Shared Savings

- The Plan's shared savings formulas from margins created in annual provider-based risk pools are based on relative value provided by payer and healthcare home.
- The Plan's incentive mechanism shows continuity from Medicaid agency to plan to provider to patients.
- Plan supports bi-directional Health Information Exchange (HIE) through additional funding to support care transitions and improved communication between PCPs and Specialists.
- Plan supports and reimburses for process outcomes and tools to continuously track and measure performance.

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- Plan's reimbursement incentives are made for increased access scheduling including incentives for evening and weekend clinic hours.
- Performance metrics are population adjusted and include sub-population measures of Social Determinants of Health.
- Performance measures are based on baseline performance improvement by Medicaid provider not comparing group to provider group.

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ELEMENT G: Effectiveness and Efficiency Incentives (other/miscellaneous)

- Provides on-line tool to submit prior authorization with real-time response.
- Paperwork reduction initiatives are planned annually in joint effort with providers.
- Plan supports unified and integrated credentialing service.
- Plan sets objectives and supports population health. Determines needs of the community; supporting expanded patient satisfaction and remediation.
- Plan provides ombudsmen service to address patient complaints and concerns.

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