KAISER PERMANENTE®

Section 80.200

Mandatory Requirements

80.210 Attachment: Transmittal Letter

See attached Transmittal Letter.

80.220 Company Background Narrative

A. The applicant shall provide a description of its company that includes: The legal name and any names under which the applicant has done business;

The legal name of the applicant is Kaiser Foundation Health Plan, Inc. The informal but widely used name Kaiser Permanente includes Kaiser Foundation Health Plan, Inc.; its sister health plans in other states; Kaiser Foundation Hospitals; the Permanente Medical Groups, such as the Hawaii Permanente Medical Group, Inc.; and an affiliation with Seattle-based Group Health Cooperative.

B. Address, telephone number and e-mail address of the applicant's Headquarter office;

One Kaiser Plaza
Oakland, CA 94612
Tel. (818) 525-4367
Contact: Susan Fleischman, MD, Vice President, Medicaid, CHIP, and Charitable Care
E-mail: Susan.D.Fleischman@kp.org

C. Date company was established;

The Kaiser Permanente Medical Care Program was established in California in October 1945.

D. Date company began operations;

Kaiser Permanente began operations in Hawaii in 1958 and began serving members in Hawaii in 1959.

E. Names and addresses of officers and directors;

Name	Title	Business Address
Christine K. Cassel, MD	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Thomas W. Chapman, EdD	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Daniel P. Garcia	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
William R. Graber	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
J. Eugene Grigsby, III	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
George C. Halvorson	Director, Chairman of the Board, Chief Executive Officer, and President	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612

Judith A. Johansen	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Kim J. Kaiser	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Philip A. Marineau	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Jenny J. Ming	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Edward Y. W. Pei	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
J. Neal Purcell	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Cynthia A. Telles, PhD.	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612

F. The size and resources, including the gross revenues and total number of employees and current number of employees in Hawaii; and

In 2010, nationwide, Kaiser Permanente had over 167,000 employees and almost 16,000 physicians representing all specialties. The Program had gross revenues of $44.2 billion.

In 2010, Kaiser Foundation Health Plan, Inc. Hawaii Region had 3,867 employees and 438 physicians representing all specialties. The Region had gross revenues of $957 million.

G. A description of any services it objects to based on moral or religious grounds as described in Section 40.300 including a description of the grounds for the objection and information on how it will provide the required services. If there are no services to which it objects, the applicant shall state that.

There are no services to which Kaiser Permanente Hawaii objects based on moral or religious grounds as described in Section 40.300 of RFP-MQD-2011-003.

80.230 <u>Attachment: Other Documentation</u>

The applicant shall attach, in the following order, completed forms provided in Appendix L:

A. The Proposal Application Identification form (Form SPO-H-200);

B. The State of Hawaii DHS Proposal Letter;

C. The Certification for Contracts, Grants, Loans and Cooperative Agreements form;

D. The Disclosure Statement (CMS required) form;

E. Disclosure Statement;

F. The Disclosure Statement (Ownership) form;

G. The Organization Structure and Financial Planning form;

H. The Financial Planning form;

I. The Controlling Interest form;

J. The Background Check Information form;

K. The Operational Certification Submission form;

L. The Grievance System form;

M. Applicant's Proof of Insurance;

N. The Wage Certification form;

O. The Standards of Conduct Declaration form;

P. The State and Federal Tax Clearance certificates from the prime applicant and, upon request from subcontractors, as assurance that all federal and state tax liabilities have been paid and that there are no significant outstanding balances owed (a statement shall be included if certificates are not available at time of submission of proposal that the certificates will be submitted in compliance with Section 20.500.);

Q. Proof of its current license to serve as a health plan in the State of Hawaii. A letter from the Insurance Division notifying the health plan of its license shall be acceptable "proof" for DHS; and

R. Certificate of Good Standing from the State of Hawaii, Department of Commerce and Consumer Affairs, Insurance Division.

See attachments for Section 80.230 A – R.

80.240 Attachment: Risk Based Capital

The applicant shall provide the most recent completed risk based capital (RBC) amount. Where applicable, the applicant shall submit separate RBC amounts for all affiliated companies and companies with the same parent company as the applicant.

See attached Risk Based Capital.

KAISER PERMANENTE®

November 28, 2011

Dona Jean Watanabe
Med-QUEST Division-Finance Office
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707-2005

Dear Ms. Watanabe:

This transmittal letter is provided in accordance with Section 80.210 of your Request for Proposals No. RFP-MQD-2011-003 Competitive Sealed Proposals: QUEST Managed Care Plans to Cover Medicaid and Other Eligible Individuals Who Are Not Aged, Blind, or Disabled ("the RFP") and sets forth representations required by that section.

A) The applicant, Kaiser Foundation Health Plan, Inc., is a California non-profit public benefit corporation and a properly licensed health plan in the State of Hawaii. Subcontractors are Hawaii Permanente Medical Group, Inc., and Kaiser Foundation Hospitals. The percentage of work to be performed by the offeror is 52%; by the Hawaii Permanente Medical Group, Inc., 18%; and by Kaiser Foundation Hospitals 30%.

B) Kaiser Foundation Health Plan, Inc. has an established provider network to serve Medicaid recipients in the State of Hawaii.

C) Kaiser Foundation Health Plan, Inc. is registered to do business in Hawaii and has a State of Hawaii General Excise Tax License. The License will be submitted to the DHS with the signed contracts (following the Contract Award date and prior to the Contract Effective Date identified in Section 20.100 in the RFP).

D) The applicant's State of Hawaii General Excise Tax License number is 10002981N.

E) The following amendments and addenda have been received subsequent to the issuance of the RFP: Amendments #1, #2, #3, #4 and #5. No other amendments or addenda are known to have been issued by the issuing office.

F) Kaiser Foundation Health Plan, Inc. does not discriminate in its employment practices with regard to race, color, creed, ancestry, age, marital status, arrest and court records, sex, including gender identity or expression, sexual orientation, religion, national origin or mental or physical handicap, except as provided by law.

Kaiser Foundation Health Plan, Inc.
3288 Moanalua Road
Honolulu, HI 96819
Phone: (808) 432-0000

G) No attempt has been made or will be made by Kaiser Foundation Health Plan, Inc. to induce any other party to submit or refrain from submitting a proposal.

H) Authorized representatives of the applicant have read, understand and agree to all provisions of the RFP.

I) It is understood that if awarded the contract, Kaiser Foundation Health Plan, Inc. will deliver the goods and services meeting or exceeding the specifications in the RFP and amendments.

J) The signatory of this transmittal letter is responsible for, or authorized to make, decisions as to the prices quoted. The offer is firm and binding. The signatory has not participated in and will not participate in any action contrary to the above conditions.

K) Kaiser Foundation Health Plan, Inc. is applying to provide services on the islands of Oahu and Maui.

J Danieley — November 28, 2011

Joan Danieley — Date
Vice President Health Plan Service and Administration
Kaiser Foundation Health Plan, Inc.

State of Hawaii

County of Honolulu } SS

First Judicial Circuit

On November 28, 2011, before me appeared Joan Yael Naomi Danieley, to me personally known, who, being by me duly sworn (or affirmed), did say that the person is the VP Health Plan Service & Administration of Kaiser Permanente, and that the instrument was signed in behalf of the corporation by authority of its board of directors, partners or trustees, and Joan Yael Naomi Danieley acknowledged the instrument to be the free act and deed of the corporation.

Document Description: Transmittal Letter to Dona Jean Watanabe - Med-Quest Division Finance Office

Doc. Date: 11/28/11 No. Pages 3

DAISY LOURDES C. FREITAS NOTARY PUBLIC No. 09-212 STATE OF HAWAII

Daisy Lourdes C Freitas 11/28/11

Notary's Signature Date

Daisy Lourdes C Freitas

Notary's Printed Name

My Commission expires: 5/31/2013

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: **Department of Human Services**

RFP NUMBER: **RFP-MQD-2011-003**

RFP TITLE: **QUEST Managed Care Plans to Cover Medicaid & Other Individuals Who Are Not Aged, Blind or Disabled**

Check one:

☒ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name:
Kaiser Foundation Health Plan, Inc.
Doing Business As:

Street Address:
711 Kapiolani Boulevard
Honolulu, HI 96813

Mailing Address:

Contact person for matters involving this application:
Name:
Carol Ganiron
Title:
Manager, Government Programs
Phone Number:
808 432-5282
Fax Number:
808 432-5260
e-mail:
carol.ganiron@kp.org

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

☒ Non-Profit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship
☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:
State: California Date: 1955

3. PROPOSAL INFORMATION

Geographic area(s):
Oahu, Maui

Target group(s):
QUEST

4. FUNDING REQUEST

FY _____	_____	FY _____	_____
FY _____	_____	FY _____	_____
FY _____	_____	FY _____	_____
		Grand Total	_____

I certify that the information provided above is to the best of my knowledge true and correct.

Carol Ganiron — *Authorized Representative Signature*

11/28/11 — *Date Signed*

Carol Ganiron, Manager, Government Programs

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for medical services. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned applicant and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications. We also affirm, by signing this proposal, that we have reviewed the reference materials in the State's documentation library and that we have used this documentation as a basis for submitting our firm fixed price cost proposal.

It also understood that failure to enter into the contract upon award shall result in forfeiture of the surety bond. We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications.

J Danielley — November 28, 2011

Authorized Applicant's Signature/Corporate Seal — Date

State of Hawaii }
SS
County of Honolulu }

First Judicial Circuit

On November 28, 2011, before me appeared Joan Yael Naomi Danieley, to me personally known, who, being by me duly sworn (or affirmed), did say that the person is the VP Health Plan Service & Administration of Kaiser Permanente, and that the instrument was signed in behalf of the corporation by authority of its board of directors, partners or trustees, and Joan Yael Naomi Danieley acknowledged the instrument to be the free act and deed of the corporation.

Document Description: State of Hawaii, Dept of Human Services, Proposal Letter

Doc. Date: 11/28/11 No. Pages 2

DAISY LOURDES C. FREITAS NOTARY PUBLIC No. 09-212 STATE OF HAWAII

Daisy Lourdes C Freitas
Notary's Signature

11/28/11
Date

Daisy Lourdes C Freitas
Notary's Printed Name

My Commission expires: 5/31/2013

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence on officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.

3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for such failure.

Applicant: Kaiser Foundation Health Plan, Inc.
Signature: [signature]
Title: Vice President Health Plan Service + Administration
Date: November 28, 2011

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the applicant fails to disclose ownership or controlling information and related party transaction as required by this policy.

Financial Disclosure requirements in accordance with 42 CFR 455.100 through 455.106 are:

455.104 formation on Ownership & Control

(1) The name and address of each person with an ownership or controlling interest in the disclosing entity.

(2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

(3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.

(4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

(5) The ownership of any subcontractor with whom the applicant has had business transactions totaling more than $25,000 during the past 12-month period.

(6) Any significant business transactions between the applicant and any wholly owned supplier or between the applicant and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

(7) Name of any person who has an ownership or controlling interest in the applicant, or is an agent or managing employee of the applicant, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b) Additional information which must be disclosed to DHS is as follows:

(1) Names and addresses of the Board of Directors of the disclosing entity.

(2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

(3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

(1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

(2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

(3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 456.101 DEFINITIONS

a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

b) "Convicted" means that a judgment of conviction, has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

c) "Disclosing entity" means a QUEST provider or health plan.

d) "Other disclosing entity" means any other QUEST disclosing entity and any entity that does not participate in QUEST but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act.

This includes:

(1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.

e) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.

f) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

g) 'Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

h) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

i) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

j) "Person with an ownership or controlling interest" means a person or corporation that:

(1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

(2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

(3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

(4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

(5) Is an officer or director of a disclosing entity that is organized as a corporation; or

(6) Is a partner in a disclosing entity that is organized as a partnership.

k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of an applicant's total operating expenses.

l) "Subcontractor" means:

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

m) "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its NHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

n) "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an applicant or by a person, persons, or other entity with an ownership or controlling interest in an applicant.

DISCLOSURE STATEMENT

Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the applicant's ability to meet QUEST objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected *in* the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the applicant. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the applicant and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact on the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period
Hospital Services	**Kaiser Foundation Hosp. Inc.**	**$286M**
Medical Services	**Hawaii Permanente Medical Group**	**$186M**

Justification

Health Plan contracts with Hospitals and Medical Group to provide or arrange hospital and medical services to members.

2. Describe all transactions between the disclosing entity *and* any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None		

Justification

DISCLOSURE STATEMENT

PLAN NAME/NO. KAISER FOUNDATION HEALTH PLAN, INC.

DISCLOSURE STATEMENT FOR THE YEAR ENDED June 30, 2011

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Health Plan, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in QUEST.

November 28, 2011
Date Signed

Joan Danieley - Vice President Health Plan Services Administration
Chief Executive Officer (Name and Title Typewritten)

11/28/11
Notarized

Signature

State of Hawaii

County of Honolulu } SS

First Judicial Circuit

On November 28, 2011, before me appeared Joan Yael Naomi Dannicley, to me personally known, who, being by me duly sworn (or affirmed), did say that the person is the VP Health Plan Service + Administration of Kaiser Permanente, and that the instrument was signed in behalf of the corporation by authority of its board of directors, partners or trustees, and Joan Yael Naomi Dannicley acknowledged the instrument to be the free act and deed of the corporation.

Document Description: Appendix L, Disclosure statement,

DAISY LOURDES C. FREITAS
NOTARY PUBLIC
No. 09-212
STATE OF HAWAII

Doc. Date: June 30, 2011 No. Pages 2

Daisy Lourdes C Fht
Notary's Signature

11/28/11
Date

Daisy Lourdes C Freitas
Notary's Printed Name

My Commission expires: 5/31/2013

DISCLOSURE STATEMENT
OWNERSHIP

Health Plan Name, Plan No.: Kaiser Foundation Health Plan, Inc.
Address (City, State, Zip): 711 Kapiolani Blvd Honolulu, HI 96813
Telephone: (808) 432-5265

For the period beginning: July 1, 2010 and ending June 30, 2011 Type of Health Plan:

- o Staff — A health plan that delivers services through a group practice established to provide health services to health plan members; doctors are salaried,
- x Group — A health plan that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- o IPA — A health plan that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- o Network — A health plan that contracts with two or more group practices to provide health services.

Type of Entity:

☐	Sole Proprietorship	☐	For-Profit
☐	Partnership	☒	Not-For-Profit
☐	Corporation	☐	Other (specify)
☐	Governmental	☐	

455.104 Information on Ownership arid Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership or control interest" means, with respect to the entity, an individual or organization who (A)(1) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of nonprofit corporation, is a member; or (ii) is the owner of a whole or part interest in *any* mortgage, deed or trust, note, or other obligation secured (in whole or in part) *by* the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or (B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Name	Address	Percent of Ownership Control
Not Applicable		

b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Percent of Ownership Control
Not Applicable		

c. Names of persons named in (a) and (b) above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

Name	Address	Percent of Ownership Control
Not Applicable		

d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

Name	Address	Percent of Ownership Control
Not applicable		

455.105 Information Related to Business Transactions

e. List the ownership of any subcontractor with whom the applicant has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
Not applicable		

f. List any significant business transactions between the applicant and any wholly owned supplier or between the applicant and any subcontractor during the five-year period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
Not applicable		

455.106 Information on Persons Convicted of Crime

g. List the names of any person who has ownership or controlling interest in the applicant, or is an agent or managing employee of the applicant and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Address	Title
None		

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan

Name/Title	Address
See attached page L-14A	

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan

Name	Title	Address
Christine K. Cassel, MD	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Thomas W. Chapman, EdD	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Daniel P. Garcia	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
William R. Graber	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
J. Eugene Grigsby, III	Director	Kaiser Foundation Health Plan, Inc. Once Kaiser Plaza Oakland, CA 94612
George C. Halvorson	Director, Chairman of the Board, Chief Executive Officer, and President	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Judith A. Johansen	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Kim J. Kaiser	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Philip A. Marineau	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Jenny J. Ming	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Edward Y. W. Pei	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
J. Neal Purcell	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612
Cynthia A. Telles, PhD.	Director	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title	Address
See attached page L-15A	

c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

Name	Address	Amount of Debt	Description of Security
N/A			

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name	Title	Address
George C. Halvorson	Chairman and Chief Executive Officer	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste. 15L Oakland, CA 94612
Bernard J Tyson	President and Chief Operating Officer	Foundation Health Plan, Inc. One Kaiser Plaza, Ste. 15L Oakland, CA 94612
Arthur M. Southam	EVP-Health Plan Operations	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Kathryn Lancaster	EVP-Chief Financial Officer	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Philip Fasano	EVP-Chief Information Officer	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Daniel P Garcia	SVP-Chief Compliance Officer	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Mark S Zemelman	SVP-General Counsel & Secretary	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Diane Gage-Lofgren	SVP-Brand Mgmt - Communications	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Charles E. Columbus	SVP-Chief Human Resources Officer	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612
Raymond J Baxter	SVP-Community Benefit, Research & Health Policy	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, Ste 15L Oakland, CA 94612

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

1) If other than a government agency:
   a. When was your organization formed? **Kaiser Foundation Health Plan, Inc.-Hawaii Region was established in 1958.**
   b. If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.
   See section 455.106, question 2(a).

2) License/Certification
   a. Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:
   See attached L-16A through L-16D.

Service Component	License/Requirement	Renewal Date

   b. Have any licenses been denied, revoked, or suspended?

   Yes _____ No __X__ If yes, please explain:

3) Civil Rights Compliance Data

   Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

   Yes _____ No __X__ If yes, please explain:

4) Handicapped Assurance

   Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the applicant's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons? (note: check with local zoning ordinances for handicapped requirements)

   Yes __X__ If yes, briefly describe how such assurances are provided.
   No _____ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

There is a written policy of non-discrimination. Interpreters are provided for persons with hearing difficulties. Staff are educated about needs of disabled persons. Subcontractors include acknowledgment that requirements for access apply to subcontractors. New construction and remodeling since 1963 includes access for disabled persons as required by law. A survey has been made of all facilities to determine where modifications of existing structures is needed. Modification is underway, based on priorities in the Americans with Disabilities Act.

Accreditation, Licensure and Certification

National Committee for Quality Assurance (NCQA)

Status:	HMO (Commercial, Medicare & Medicaid) Accreditation with *Excellent* status
KPHI Entity:	Kaiser Foundation Health Plan, Inc.- Hawaii
Dates:	May 11, 2010 to May 11, 2013, next survey scheduled February 2013

NCQA - Disease Management Certification

Status:	KP Care Management Institute (CMI) Certified
KPHI Entity:	CMI's Diabetes, Asthma, CHF, Cardiovascular Disease and Depression Programs
Dates:	October 4, 2010 to October 4, 2012

NCQA – PPC Patient Centered Medical Home Recognition

Status:	Multi-site Level 3 Recognition
KPHI Entity:	KP HI Clinics: Hawaii Kai, Maui Lani, Lahaina, Kihei, Honolulu, Mapunapuna, Waimea, Kona, Kailua, Waipio, Nanaikeola, Kapolei, Koolau, Kahuku, So. Kona, Hilo
Dates:	October 15, 2010 to October 15, 2013

Health Services Advisory Group – Medicaid Survey

Status:	State Contract Requirements Met
KPHI Entity:	Kaiser Foundation Health Plan of Hawaii, Inc.
Dates:	April 2011, next anticipated review April 2012

Centers for Medicare and Medicaid Services (CMS)

Status:	Contract Requirements Met
KPHI Entity:	Kaiser Foundation Health Plan of Hawaii, Inc.
Dates:	2012 contract approved on 8/31/2011, next review 2012

Joint Commission - Hospital Accreditation

Status:	Accredited, Full Compliance with all Applicable Standards
KPHI Entity:	Kaiser Moanalua Medical Center
Dates:	Accredited May 2, 2009, next unannounced survey between October 2010 to August 2012

Joint Commission - Home Care Accreditation

Status:	Accredited, Full Compliance with all Applicable Standards
KPHI Entity:	Kaiser Permanente Continuing Care Services (Home Health / Hospice)
Dates:	Accredited May 2, 2009, next unannounced survey between October 2010 to August 2012

Accreditation, Licensure and Certification

State of Hawaii Department of Health

Status:	Licensed
KPHI Entity:	Honolulu Ambulatory Surgery Center (ASC)
Dates:	Next renewal October 31, 2012

State of Hawaii Department of Health

Status:	Licensed
KPHI Entity:	Wailuku Ambulatory Surgery Center (ASC)
Dates:	Next renewal September 20, 2013

Nuclear Regulatory Commission

Status:	Licensed
KPHI Entity:	Nuclear Medicine
Dates:	Next renewal April 30, 2015

American College of Radiology (ACR)

Status:	Accreditation
KPHI Entity:	Kaiser MOA Radiology, Mammography
Dates:	Next renewal September 4, 2014

Department of Health and Human Services

Status:	FDA / Mammography Quality Standards Act (MQSA) Certification
KPHI Entity:	• Moanalua Hospital expiration - 9/4/2014 • Honolulu Clinic Mammography- 10/8/2012 • Wailuku Clinic Mammography – 6/23/2012 • Waipio Clinic Mammography - 5/21/2013
Dates:	Next renewal varies by site

Accreditation, Licensure and Certification

KPHI Entity:	Clinical Laboratory Improvement Amendments (CLIA) Expiration Date	College of American Pathologists (CAP) Expiration Date	Class I or II Permit License Expiration Date
Regional Laboratory (Moanalua)	Accredtitation 2/27/2013	AABB / TJC 3/14/2013	License 5/31/2012
Honolulu Clinic Lab	Compliance 2/8/2013	N/A	License 5/31/2012
Koolau Clinic Lab	Compliance 12/26/2011	N/A	License 5/31/2012
Kailua Clinic Lab	Compliance 12/31/2011	N/A	Class I 5/31/2012
Hawaii Kai Clinic Lab	Waiver 12/31/2012	N/A	Class I 5/31/2012
Nanaikeola Clinic Lab	Compliance 2/7/2013	N/A	License 5/31/2012
Wailuku Clinic Lab	Compliance 11/4/2013	N/A	Class I 5/31/2012
Lahaina Clinic Lab	Compliance 2/6/2013	N/A	License 5/31/2012
Kona Clinic Lab	Waiver 4/8/2013	N/A	Class I 5/31/2012
Kihei Clinic Lab	Compliance 2/2/2013	N/A	License 5/31/2012
Kahuku Clinic Lab	Waiver 3/26/2013	N/A	Class I 5/31/2012
Hilo Clinic Lab	Waiver 7/13/2013	N/A	Class I 7/31/2013
Waimea Clinic Lab	Waiver 7/13/2013	N/A	Class I 7/31/2013
Kapolei Clinic Lab	Waiver 7/7/2013	N/A	Class I 5/31/2012
Waipio Clinic Lab	Compliance 7/20/2013	N/A	License 5/31/2012
Maui Lani Clinic Lab	Compliance 4/27/2013	N/A	License 5/31/2012
Mapunapuna Clinic Lab	Registration 12/31/2011	N/A	Class I 5/31/2012
South Kona Clinic Lab	Waiver 7/20/2012	N/A	Class I 6/30/2012

Accreditation, Licensure and Certification

KPHI Entity:	Clinical Laboratory Improvement Amendments (CLIA) Expiration Date	Class I or II Permit License Expiration Date
Moanalua Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Moanalua Hospital PPMP	PPMP - 9/21/2013	Class I - 10/31/2013
Honolulu Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Koolau Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Kailua Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Hawaii Kai Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Nanaikeola Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Wailuku Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Lahaina Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Kona Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Kihei Clinic PPMP	PPMP - 11/30/2012	Class I - 5/31/2012
Kahuku Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Hilo Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Waimea Clinic PPMP	PPMP - 2/12/2012	Class I - 5/31/2012
Kapolei Clinic PPMP	PPMP - 8/11/2012	Class I - 5/31/2012
Waipio Clinic PPMP	PPMP - 10/6/2012	Class I - 5/31/2012
Maui Lani Clinic PPMP	PPMP - 11/14/2012	Class I - 5/31/2012
Mapunapuna Clinic PPMP	PPMP - 5/19/2013	Class I - 5/31/2012
Healthworks (Honolulu)	Waiver - 1/30/2013	Class I - 5/31/2012
Center For Health Research	Waiver - 8/21/2013	Class I - 5/31/2012
Point-of-Care Lab (Moanalua)	Accreditation - 11/30/2012	License - 1/31/2013
Specialty Care Inc. (Moanalua)	Accreditation - 11/17/2011	License - 1/31/2013
South Kona Clinic PPMP	PPMP - 7/19/2012	Class I - 6/30/2012
South Kona Clinic Lab	Waiver - 7/20/2012	Class I - 6/30/2012

5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, Plan Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

None

6) Federal Government Suspension/Exclusion

Has applicant been suspended or excluded from any federal government programs for any reason?

Yes _____ No X If yes, please explain:

d. Are management letters on internal controls issued by the accounting firm?

Yes ____X____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the applicant, by its submission, certifies the letter is unaltered.

See Exhibit III

If no, the applicant shall provide a comprehensive description of internal control systems. The applicant is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

e. Do you have any uncorrected audit exceptions?

Yes _____ No ____X____

If yes, provide a copy of the auditor's management letter (see 4(d) of this form for instructions regarding submittal).

5) Does the applicant have an accounting manual?

Yes ____X____ No _____

If no, the applicant must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The applicant agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the applicant have a formal basis to allocate indirect costs reflected in your financial statement?

Yes ____X____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

See attached L-19A

7) What types of liability insurance does the applicant have? See attached L-19A

a. With what company(s)? _____

b. What is the amount of coverage for each type of insurance? _____

See attached L-19A

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the applicant or its owner(s).

Not available

Financial Planning Form

1) Is the applicants accounting system based on a cash, accrual, or modified method?
   a. Cash [ ]
   b. Accrual [ ]
   c. Modified [X] Give brief explanation **The statements are prepared on a modified basis using Statutory Accounting Principles.**

2) Does the applicant prepare an annual financial statement?

   Yes X No _____ If yes, please explain:

   See Exhibit 1

3) Are interim financial statements prepared? Yes X No _____

   a. If yes, how often are they prepared? **Quarterly for NAIC filings and monthly for company reporting.**

   b. If yes, are footnotes and supplementary schedules an integral part of the statements?
      Yes _____ No X

   c. If yes, are actuals analyzed and compared to budgeted amounts?
      Yes X No _____

   d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

   See Exhibit II

4) Is the applicant audited by an independent accounting firm/accountant?
   Yes X No _____

   a. If yes, how often are audits conducted? **Annually**

   b. By whom are they conducted? **KPMG LLP, Honolulu**

   c. Did this auditor perform that applicant's last audit?
      Yes X No _____
      If no, provide the name, address, and telephone number of the firm that performed the applicant's last audit.

6. Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated. **Indirect costs are allocated using a single step-down methodology. The allocation bases vary dependent on the cost being allocated. However, the prevailing bases are worked hours and total dollars.**

7-7b. What types of liability insurance does the applicant have? With what company(s)? What is the amount of coverage for each type of insurance?

Commercial General Liability Insurance
Insurance Company: N/A – self-insured
Coverage: $3 million per occurrence

Hospital/Physician Liability Insurance
Insurance Company: N/A – self-insured
Coverage: $3 million per occurrence

Automobile Liability Insurance
Insurance Company: Marsh Risk & Insurance Services
Coverage: $1 million per occurrence

Workers Compensation and Employers' Liability Insurance
Insurance Company: Marsh Risk & Insurance Services
Coverage: $5 million per occurrence

9) Are there any suits, judgements, tax deficiencies, or claims pending against the applicant?
Yes X No _____

Briefly describe each item and indicate probable amount.
There are no pending judgements or tax deficiencies against the Plan. There are lawsuits and claims pending against the plan for which adequate reserves have been established.

10) Has the applicant or its owner(s) ever gone through bankruptcy?
Yes _____ No X

If yes, when? _____

11) Do(es) the applicant's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?
Yes X No _____

If yes, describe the dollar amount(s) and source(s) of all funding. Current operations.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

12) Does the applicant have a performance bonding mechanism in accordance with DHS rules?
Yes X No _____

If yes, provide the following information:

Amount of Bond	$ $4,000,000
Term of Bond	June 30, 2010 – June 30, 2012
Bonding Company	Safeco Insurance Company of America
Restrictions on Bond	

If no, describe how the applicant intends to provide a bond and/or security to meet established DHS rules.

13) Does the applicant have a financial management system to account for incurred, but not reported liabilities?

Yes X No ____

If no, the applicant must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, The applicant, regardless of response (either yes or no) must complete items "a" through "h" below.

a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes X No ____

b. How often are IBNRs projected? Monthly

c. Identify all major data sources most often used. Claims reviewed and paid, and membership data.

d. Are data from open referrals and prior notifications used?

Yes X No ____ If so, how? See L-21A

e. Are detailed written procedures maintained? Yes X No ____

f. Are IBNR amounts compared with actuals and adjusted when necessary?

Yes X No ____ See L-21A

g. Is the basis of periodic IBNR estimates well documented?

Yes X No ____

h. The applicant must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the applicant is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the applicant will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

Kaiser Hawaii uses a claims IBNR model developed internally by Kaiser National and administered locally by a qualified Actuary. Actual run out data is used and compared to IBNR estimates on a monthly basis.

See Exhibit IV

13d. Are data from open referrals, and prior notifications used? **Yes**

If so, how? **Significant open referrals are estimated based on knowledge of the referral.**

13f. Are IBNR amounts compared with actuals and adjusted when necessary? **Yes**

Quarterly, the referrals and claims accrual is certified by an actuary.

14) Does the applicant have a full-time (100%) controller or chief financial officer?

Yes X No _____ If yes, enter name: ____

Thomas Risse, Chief Financial Officer (808) 432-5276

15) Are the following items reported on the applicant's financial statements?

a. Medicare reimbursement Yes X No ____

b. Other third-party recoveries Yes X No ____

If no, explain why.

1 1 5 3 8 2 0 1 1 2 0 1 0 0 1 0 2

QUARTERLY STATEMENT

AS OF JUNE 30, 2011

OF THE CONDITION AND AFFAIRS OF THE

Kaiser Foundation Health Plan, Inc. Hawaii Region

NAIC Group Code 0601 (Current Period), 0601 (Prior Period) NAIC Company Code 11538 Employer's ID Number 94-1340523

Organized under the Laws of Hawaii, State of Domicile or Port of Entry Hawaii

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health [ ] Property/Casualty [ ] Hospital, Medical & Dental Service or Indemnity [ ]
Dental Service Corporation [ ] Vision Service Corporation [ ] Health Maintenance Organization [X]
Other [ ] Is HMO, Federally Qualified? Yes [X] No [ ]

Incorporated/Organized 03/11/1955 Commenced Business 02/18/1958

Statutory Home Office 711 Kapiolani Boulevard (Street and Number), Honolulu, HI 96813 (City, State and Zip Code)

Main Administrative Office 711 Kapiolani Boulevard (Street and Number) Honolulu, HI 96813 (City or Town, State and Zip Code) 808-432-5955 (Area Code) (Telephone Number)

Mail Address 711 Kapiolani Boulevard (Street and Number or P.O. Box), Honolulu, HI 96813 (City or Town, State and Zip Code)

Primary Location of Books and Records 711 Kapiolani Boulevard (Street and Number) Honolulu, HI 96813 (City, State and Zip Code) 808-432-5910 (Area Code) (Telephone Number)

Internet Web Site Address http://www.kp.org

Statutory Statement Contact Stephanie Otsuka (Name) 808-432-5910 (Area Code) (Telephone Number) (Extension)
stephanie.pw.otsuka@kp.org (E-Mail Address) 808-432-5495 (Fax Number)

OFFICERS

Name	Title	Name	Title
Janet Liang	Regional President, Hawaii	Mark S Zemelman	Sr VP, General Counsel and Secretary
Thomas Ralph Meier	Sr Vice President & Treasurer	Thomas Risse	CFO & VP, Business Operations

OTHER OFFICERS

Daniel Peter Garcia	Sr VP & Chief Compliance Officer	Anthony Barrueta	Sr VP, Government Relations
Arthur Milton Southam MD	Executive VP- Health Plan Operations	Deborah Stokes	Sr VP, Corp Controller & Chief Accounting Officer
Mitchell Jay Goodstein	Sr VP - Actuarial, Underwriting & Pricing	George Charles Halvorson	Chairman of the Board & CEO
Philip Fasano	Executive VP & Chief Information Officer	Frank Richardson	Assistant Secretary - Hawaii
Jed Weissberg MD	Sr VP - Quality and Care Delivery Excellence	Raymond Joseph Baxter	Sr VP - Comm Benefit, Research & Health Policy
Jerry Clyde Fleming	Sr VP - National Health Plan Manager	Bernard James Tyson	President & Chief Operating Officer
Herman M Weil	Sr VP - Medicare and Government Programs	Indrajit Obeysekere	Assistant Secretary
Victoria Bleiberg Zatkin	Assistant Secretary	Kathryn Lee Lancaster	Executive VP & Chief Financial Officer
Jennifer Marie Gardner	Assistant Secretary	Diane Gage Lofgren	Sr VP - Brand Strategy, Comm & Public Relations
Benjamin Chu MD	Group President, Southern California & Hawaii	Charles E Columbus	Sr VP & Chief Human Resources Officer
Don H Orndoff	Sr VP, National Facilities Services	Judith M Mears	Assistant Secretary
Rochelle M Roth	Assistant Secretary	Jacqueline Sellers	Assistant Secretary

DIRECTORS OR TRUSTEES

Daniel Peter Garcia	Christine Karen Cassel MD	George Charles Halvorson	Thomas William Chapman EdD
William Raymond Graber	Jefferson Eugene Grigsby, III PhD	Philip Albert Marineau	Japser Neal Purcell
Cynthia Ann Telles PhD	Jenny Jang Ming	Kim John Kaiser	Judith Ann Johansen JD
Edward Ying Wah Pei			

State of ..... See attached .....
County of ..... See attached ..... ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Janet Liang	Mark S Zemelman	Thomas Risse
Regional President, Hawaii	Sr VP, General Counsel and Secretary	CFO & VP, Business Operations, Hawaii

Subscribed and sworn to before me this
See attached day of See attached, 2011

See attached, See attached
See attached
See attached

a. Is this an original filing? Yes [X] No [ ]

b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached

JURAT - Attachment

KAISER FOUNDATION HEALTH PLAN, INC.

(A California Nonprofit Corporation; Tax Exempt Under Internal Revenue Code § 501(c)(3))

HAWAII REGION OFFICERS

Janet Liang	Regional President
Brian Yoshii	VP, Strategic Support Services
Winona White	VP, Human Resources
Liza Villanueva	Continuing Care & Ancillary Administrator
Joan Danieley	VP, Health Plan Service & Administration
Frank Richardson	VP & Regional Counsel, Legal & Government Relations
Thomas Risse	CFO & VP, Business Operations
Susan Murray	VP, Quality, Safety & Service
Sharon Thomson	VP, Public Relations, Communications & Brand Management
Jason Hall	VP & Chief Administrative Officer
Suzanne Jester	Interim VP, Marketing, Sales & Business Development

ASSETS

	Current Statement Date			4
	1	2	3	
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	December 31 Prior Year Net Admitted Assets
1. Bonds			0	0
2. Stocks:				
2.1 Preferred stocks			0	0
2.2 Common stocks			0	0
3. Mortgage loans on real estate:				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate:				
4.1 Properties occupied by the company (less $ encumbrances)	97,718,250		97,718,250	99,398,879
4.2 Properties held for the production of income (less $ encumbrances)	8,799,141		8,799,141	8,941,606
4.3 Properties held for sale (less $ encumbrances)			0	0
5. Cash ($ (2,727,792)), cash equivalents ($ 0) and short-term investments ($ 0)	(2,727,792)		(2,727,792)	4,248,805
6. Contract loans (including $ premium notes)			0	0
7. Derivatives			0	0
8. Other invested assets	0		0	0
9. Receivables for securities			0	0
10. Securities lending reinvested collateral assets			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	103,789,599	0	103,789,599	112,589,290
13. Title plants less $ charged off (for Title insurers only)			0	0
14. Investment income due and accrued			0	0
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	21,548,445	124,966	21,423,479	16,491,479
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums			0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	0
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans			0	0
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset			0	0
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software	5,882	702	5,180	0
21. Furniture and equipment, including health care delivery assets ($ 20,883,498)	34,025,699	13,192,201	20,833,498	21,081,035
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	149,109,746		149,109,746	142,640,075
24. Health care ($ 9,792,469) and other amounts receivable	9,792,469		9,792,469	2,539,579
25. Aggregate write-ins for other than invested assets	8,649,761	5,353,707	3,296,054	2,155,480
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	326,921,601	18,671,576	308,250,025	297,496,938
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	326,921,601	18,671,576	308,250,025	297,496,938
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Long-term Deposits			0	0
2502. Other assts nonadmitted	3,055,288	3,055,288	0	0
2503. Other receivables	5,164,805	1,868,751	3,296,054	2,155,480
2598. Summary of remaining write-ins for Line 25 from overflow page	429,668	429,668	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	8,649,761	5,353,707	3,296,054	2,155,480

LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less $ ..... reinsurance ceded)	12,193,032		12,193,032	12,327,461
2. Accrued medical incentive pool and bonus amounts			0	0
3. Unpaid claims adjustment expenses	635,236		635,236	730,972
4. Aggregate health policy reserves			0	0
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserve			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	13,537,423		13,537,423	15,172,782
9. General expenses due or accrued	10,942,957		10,942,957	14,254,187
10.1 Current federal and foreign income tax payable and interest thereon (including $ ..... on realized gains (losses))			0	0
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable			0	0
12. Amounts withheld or retained for the account of others	15,856,408		15,856,408	13,645,520
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)			0	0
15. Amounts due to parent, subsidiaries and affiliates	15,723,981		15,723,981	17,321,503
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ ..... authorized reinsurers and $ ..... unauthorized reinsurers)			0	0
20. Reinsurance in unauthorized companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ 21,004,604 current)	99,516,729	0	99,516,729	92,047,712
24. Total liabilities (Lines 1 to 23)	168,405,766	0	168,405,766	165,500,137
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	0
26. Common capital stock	XXX	XXX		0
27. Preferred capital stock	XXX	XXX		0
28. Gross paid in and contributed surplus	XXX	XXX	25,374	28,624
29. Surplus notes	XXX	XXX		0
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	139,818,885	131,968,177
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26) $ .....)	XXX	XXX		0
32.2 ..... shares preferred (value included in Line 27) $ .....)	XXX	XXX		0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	139,844,259	131,996,801
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	308,250,025	297,496,938
DETAILS OF WRITE-INS				
2301. Self-Insurance	12,556,399		12,556,399	11,380,116
2302. Post-Retirement	40,130,692		40,130,692	39,269,008
2303. Deferred Medicare Payments			0	0
2398. Summary of remaining write-ins for Line 23 from overflow page	46,829,638	0	46,829,638	41,398,588
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	99,516,729	0	99,516,729	92,047,712
2501.	XXX	XXX		
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	1,381,039	1,583,199	2,720,744
2.	Net premium income (including $ non-health premium income)	XXX	515,075,322	461,033,475	932,562,924
3.	Change in unearned premium reserves and reserve for rate credits	XXX		0	0
4.	Fee-for-service (net of $ medical expenses)	XXX	1,276,479	974,632	2,823,170
5.	Risk revenue	XXX		0	0
6.	Aggregate write-ins for other health care related revenues	XXX	11,284,138	11,300,823	21,626,838
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	527,635,939	473,308,930	957,012,932
	Hospital and Medical:				
9.	Hospital/medical benefits		307,411,501	278,056,411	550,686,263
10.	Other professional services		3,642,897	3,563,941	7,503,728
11.	Outside referrals		28,175,858	27,285,573	52,239,338
12.	Emergency room and out-of-area		16,048,590	11,159,466	27,345,819
13.	Prescription drugs		64,476,770	59,914,641	123,167,865
14.	Aggregate write-ins for other hospital and medical	0	85,305,165	83,514,435	169,251,794
15.	Incentive pool, withhold adjustments and bonus amounts			0	0
16.	Subtotal (Lines 9 to 15)	0	505,060,781	463,494,467	930,194,807
	Less:				
17.	Net reinsurance recoveries			0	0
18.	Total hospital and medical (Lines 16 minus 17)	0	505,060,781	463,494,467	930,194,807
19.	Non-health claims (net)			0	0
20.	Claims adjustment expenses, including $ 1,243,034 cost containment expenses		2,234,557	2,024,834	4,019,787
21.	General administrative expenses		17,320,439	16,340,854	33,515,177
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)			0	0
23.	Total underwriting deductions (Lines 18 through 22)	0	524,615,777	481,860,155	967,729,771
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	3,020,162	(8,551,225)	(10,716,839)
25.	Net investment income earned		2,588,547	2,724,079	5,610,723
26.	Net realized capital gains (losses) less capital gains tax of $			0	0
27.	Net investment gains (losses) (Lines 25 plus 26)	0	2,588,547	2,724,079	5,610,723
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $			0	0
29.	Aggregate write-ins for other income or expenses	0	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	5,608,709	(5,827,146)	(5,106,116)
31.	Federal and foreign income taxes incurred	XXX		0	0
32.	Net income (loss) (Lines 30 minus 31)	XXX	5,608,709	(5,827,146)	(5,106,116)
	DETAILS OF WRITE-INS				
0601.	Other Healthcare Revenue	XXX	2,224,881	2,390,582	4,843,243
0602.	Other Member Revenue	XXX	5,692,521	3,263,079	6,862,841
0603.	Other Non-Member Revenue	XXX	3,366,736	5,647,162	9,920,754
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX	11,284,138	11,300,823	21,626,838
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798) (Line 7 above)	XXX	0	0	0
1401.	Managed Optical Expenditures		3,557,759	3,419,795	6,856,967
1402.	Other Benefits - Managed Clinic & Durable Equipment		81,747,406	80,094,640	162,394,827
1403.					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)	0	85,305,165	83,514,435	169,251,794
2901.					
2902.					
2903.					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)	0	0	0	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year
	CAPITAL & SURPLUS ACCOUNT:			
33.	Capital and surplus prior reporting year	131,996,801	130,689,739	130,689,739
34.	Net income or (loss) from Line 32	5,608,709	(5,827,146)	(5,106,116)
35.	Change in valuation basis of aggregate policy and claim reserves		0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $		0	0
37.	Change in net unrealized foreign exchange capital gain or (loss)		0	0
38.	Change in net deferred income tax		0	0
39.	Change in nonadmitted assets	1,236,646	2,551,913	3,930,382
40.	Change in unauthorized reinsurance	0	0	0
41.	Change in treasury stock		0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles		0	0
44.	Capital Changes:			
	44.1 Paid in		0	0
	44.2 Transferred from surplus (Stock Dividend)		0	0
	44.3 Transferred to surplus		0	0
45.	Surplus adjustments:			
	45.1 Paid in	(3,250)	(3,267)	20,717
	45.2 Transferred to capital (Stock Dividend)	0	0	0
	45.3 Transferred from capital		0	0
46.	Dividends to stockholders		0	0
47.	Aggregate write-ins for gains or (losses) in surplus	1,005,353	(751,611)	2,462,079
48.	Net change in capital and surplus (Lines 34 to 47)	7,847,458	(4,030,111)	1,307,062
49.	Capital and surplus end of reporting period (Line 33 plus 48)	139,844,259	126,659,628	131,996,801
	DETAILS OF WRITE-INS			
4701.	Additional Pension Liability	1,005,353	(751,611)	2,462,079
4702.	Rounding		0	0
4703.			0	0
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)	1,005,353	(751,611)	2,462,079

CASH FLOW

	1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
Cash from Operations			
1. Premiums collected net of reinsurance	508,821,968	453,109,108	939,982,327
2. Net investment income	5,408,469	5,477,346	11,137,274
3. Miscellaneous income	5,534,086	5,298,675	23,720,044
4. Total (Lines 1 to 3)	519,764,523	463,885,129	974,839,645
5. Benefit and loss related payments	505,195,210	463,963,424	930,713,694
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		0	0
7. Commissions, expenses paid and aggregate write-ins for deductions	22,961,962	14,645,656	33,084,902
8. Dividends paid to policyholders		0	0
9. Federal and foreign income taxes paid (recovered) net of $ tax on capital gains (losses)	0	0	0
10. Total (Lines 5 through 9)	528,157,172	478,609,080	963,798,596
11. Net cash from operations (Line 4 minus Line 10)	(8,392,649)	(14,723,951)	11,041,049
Cash from Investments			
12. Proceeds from investments sold, matured or repaid:			
12.1 Bonds	0	0	0
12.2 Stocks	0	0	0
12.3 Mortgage loans	0	0	0
12.4 Real estate	0	0	0
12.5 Other invested assets	0	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0	0
12.7 Miscellaneous proceeds	0	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0	0
13. Cost of investments acquired (long-term only):			
13.1 Bonds	0	0	0
13.2 Stocks	0	0	0
13.3 Mortgage loans	0	0	0
13.4 Real estate	978,369	411,660	1,245,989
13.5 Other invested assets	0	0	0
13.6 Miscellaneous applications	18,459	123,582	31,503
13.7 Total investments acquired (Lines 13.1 to 13.6)	996,828	535,242	1,277,492
14. Net increase (or decrease) in contract loans and premium notes	0	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(996,828)	(535,242)	(1,277,492)
Cash from Financing and Miscellaneous Sources			
16. Cash provided (applied):			
16.1 Surplus notes, capital notes	0	0	0
16.2 Capital and paid in surplus, less treasury stock	(3,250)	(3,267)	20,717
16.3 Borrowed funds	0	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities		0	0
16.5 Dividends to stockholders	0	0	0
16.6 Other cash provided (applied)	2,416,130	15,095,321	(3,968,969)
17. Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	2,412,880	15,092,054	(3,948,252)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(6,976,597)	(167,139)	5,815,305
19. Cash, cash equivalents and short-term investments:			
19.1 Beginning of year	4,248,805	(1,566,500)	(1,566,500)
19.2 End of period (Line 18 plus Line 19.1)	(2,727,792)	(1,733,639)	4,248,805

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	229,186	15,220	150,752	0	0	0	12,730	24,734	25,750	0
2 First Quarter	231,097	14,377	151,601	0	0	0	13,033	24,991	27,095	0
3 Second Quarter	229,364	14,576	149,513				13,044	25,138	27,093	
4. Third Quarter	0									
5. Current Year	0									
6 Current Year Member Months	1,381,039	43,572	1,141,494				39,149	75,224	81,600	
Total Member Ambulatory Encounters for Period:										
7. Physician	393,229	16,856	223,470				22,737	78,932	51,234	
8. Non-Physician	179,061	8,510	102,043				10,450	37,208	20,850	
9. Total	572,290	25,366	325,513	0	0	0	33,187	116,140	72,084	0
10. Hospital Patient Days Incurred	37,038	1,143	16,381				2,104	13,910	3,500	
11. Number of Inpatient Admissions	6,933	187	3,170				394	2,377	805	
12. Health Premiums Written(a)	515,075,322	20,224,798	273,464,554				32,735,469	159,629,267	29,021,234	
13. Life Premiums Direct	0									
14. Property/Casualty Premiums Written	0									
15. Health Premiums Earned	515,075,322	20,224,798	273,464,554				32,735,469	159,629,267	29,021,234	
16. Property/Casualty Premiums Earned	0									
17. Amount Paid for Provision of Health Care Services	505,195,210	20,706,326	267,426,240				31,266,573	144,833,891	40,962,180	
18. Amount Incurred for Provision of Health Care Services	505,060,781	13,182,300	273,885,991				31,576,598	145,948,028	40,467,864	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims unpaid (Reported)						
0199999 Individually listed claims unpaid	0	0	0	0	0	0
0299999 Aggregate accounts not individually listed-uncovered						0
0399999 Aggregate accounts not individually listed-covered	5,755,828	2,343,128	899,155	366,404	2,828,517	12,193,032
0499999 Subtotals	5,755,828	2,343,128	899,155	366,404	2,828,517	12,193,032
0599999 Unreported claims and other claim reserves	XXX	XXX	XXX	XXX	XXX	
0699999 Total amounts withheld	XXX	XXX	XXX	XXX	XXX	
0799999 Total claims unpaid	XXX	XXX	XXX	XXX	XXX	12,193,032
0899999 Accrued medical incentive pool and bonus amounts	XXX	XXX	XXX	XXX	XXX	

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability Dec. 31 of Prior Year
1. Comprehensive (hospital and medical)	5,940,604	282,191,961	327,971	6,677,204	6,268,575	8,069,449
2. Medicare Supplement					0	0
3. Dental only					0	0
4. Vision only					0	0
5. Federal Employees Health Benefits Plan	906,993	30,359,580	40,056	815,505	947,049	545,536
6. Title XVIII - Medicare	4,108,281	140,725,610	176,491	3,593,213	4,284,772	2,655,567
7. Title XIX - Medicaid	1,629,111	39,333,070	26,340	536,252	1,655,451	1,056,909
8. Other health					0	0
9. Health subtotal (Lines 1 to 8)	12,584,989	492,610,221	570,858	11,622,174	13,155,847	12,327,461
10. Healthcare receivables (a)					0	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts					0	0
13. Totals (Lines 9-10+11+12)	12,584,989	492,610,221	570,858	11,622,174	13,155,847	12,327,461

(a) Excludes $ loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1) Summary of Significant Accounting Policies

No change

2) Accounting Changes and Corrections of Errors

No change

3) Business Combinations and Goodwill

No change

4) Discontinued Operations

No change

5) Investments

No change

6) Joint Ventures, Partnerships & Limited Liability Companies

No change

7) Investment Income

No change

8) Derivative Instruments

No change

9) Income Taxes

No change

10) Information Concerning Parent, Subsidiaries and Affiliates

No change

11) Debt

No change

12) Retirement Plans, Deferred Compensation, Post-employment, Employment Benefits and Compensated Absences and other Post-retirement Benefit Plans

No change

13) Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

No change

14) Contingencies

No change

15) Leases

No change

16) Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

No change

17) Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

No change

18) Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

No change

NOTES TO FINANCIAL STATEMENTS

19) Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No change

20) Fair Value Measurement

No change

21) Other Items

No change

22) Events Subsequent

No change

23) Reinsurance

No change

24) Retrospectively Rated Contracts and Contract Subject to Redetermination

No change

25) Change in Incurred Claims and Claim Adjustment Expenses

No change

26) Intercompany Pooling Arrangements

No change

27) Structured Settlements

No change

28) Health Care Receivables

No change

29) Participating Policies

No change

30) Premium Deficiency Reserves

No change

31) Anticipated Salvage and Subrogation

No change

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES
GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? ..... Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? ..... Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes [X] No [ ]

2.2 If yes, date of change: 06/23/2011

3. Have there been any substantial changes in the organizational chart since the prior quarter end? ..... Yes [ ] No [X]

If yes, complete the Schedule Y - Part 1 - organizational chart.

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes [ ] No [X]

4.2 If yes, provide the name of entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? ..... Yes [ ] No [ ] NA [X]

If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made. .....

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. .....

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). .....

6.4 By what department or departments?

.....

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes [ ] No [ ] NA [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes [ ] No [ ] NA [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes [ ] No [X]

7.2 If yes, give full information:

.....

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? ..... Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

.....

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? ..... Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Office of Thrift Supervision (OTS), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.]

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 OTS	6 FDIC	7 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? ..... Yes [X] No [ ]

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

(c) Compliance with applicable governmental laws, rules and regulations;

(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

(e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:

.....

9.2 Has the code of ethics for senior managers been amended? ..... Yes [ ] No [X]

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).

.....

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? ..... Yes [ ] No [X]

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

.....

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? ..... Yes [X] No [ ]

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: ..... $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) ..... Yes [ ] No [X]

11.2 If yes, give full and complete information relating thereto:

.....

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: ..... $ .....

13. Amount of real estate and mortgages held in short-term investments: ..... $ .....

14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? ..... Yes [ ] No [X]

14.2 If yes, please complete the following:

		1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21	Bonds	$	$
14.22	Preferred Stock	$	$
14.23	Common Stock	$	$
14.24	Short-Term Investments	$	$
14.25	Mortgage Loans on Real Estate	$	$
14.26	All Other	$	$
14.27	Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 0
14.28	Total Investment in Parent included in Lines 14.21 to 14.26 above	$	$

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? ..... Yes [ ] No [X]

15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? ..... Yes [ ] No [ ]
If no, attach a description with this statement.

GENERAL INTERROGATORIES

16. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III – General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook?..... Yes [ ] No [X]

16.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address

16.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

16.3 Have there been any changes, including name changes, in the custodian(s) identified in 16.1 during the current quarter? ..... Yes [ ] No [X]

16.4 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

16.5 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository	2 Name(s)	3 Address

17.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Securities Valuation Office been followed? ..... Yes [X] No [ ]

17.2 If no, list exceptions:

.....

GENERAL INTERROGATORIES

PART 2 - HEALTH

1.

	1 Amount
1. Operating Percentages:	
1.1 A&H loss percent	98.3%
1.2 A&H cost containment percent	0.2%
1.3 A&H expense percent excluding cost containment expenses	%
2.1 Do you act as a custodian for health savings accounts?	Yes [ ] No [X]
2.2 If yes, please provide the amount of custodial funds held as of the reporting date.	$
2.3 Do you act as an administrator for health savings accounts?	Yes [ ] No [X]
2.4 If yes, please provide the balance of the funds administered as of the reporting date.	$

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 Federal ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Is Insurer Authorized? (Yes or No)
			ACCIDENT AND HEALTH AFFILIATES			
			ACCIDENT AND HEALTH NON-AFFILIATES			
			LIFE AND ANNUITY AFFILIATES			
			LIFE AND ANNUITY NON-AFFILIATES			
			PROPERTY/CASUALTY AFFILIATES			
			PROPERTY/CASUALTY NON-AFFILIATES			

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

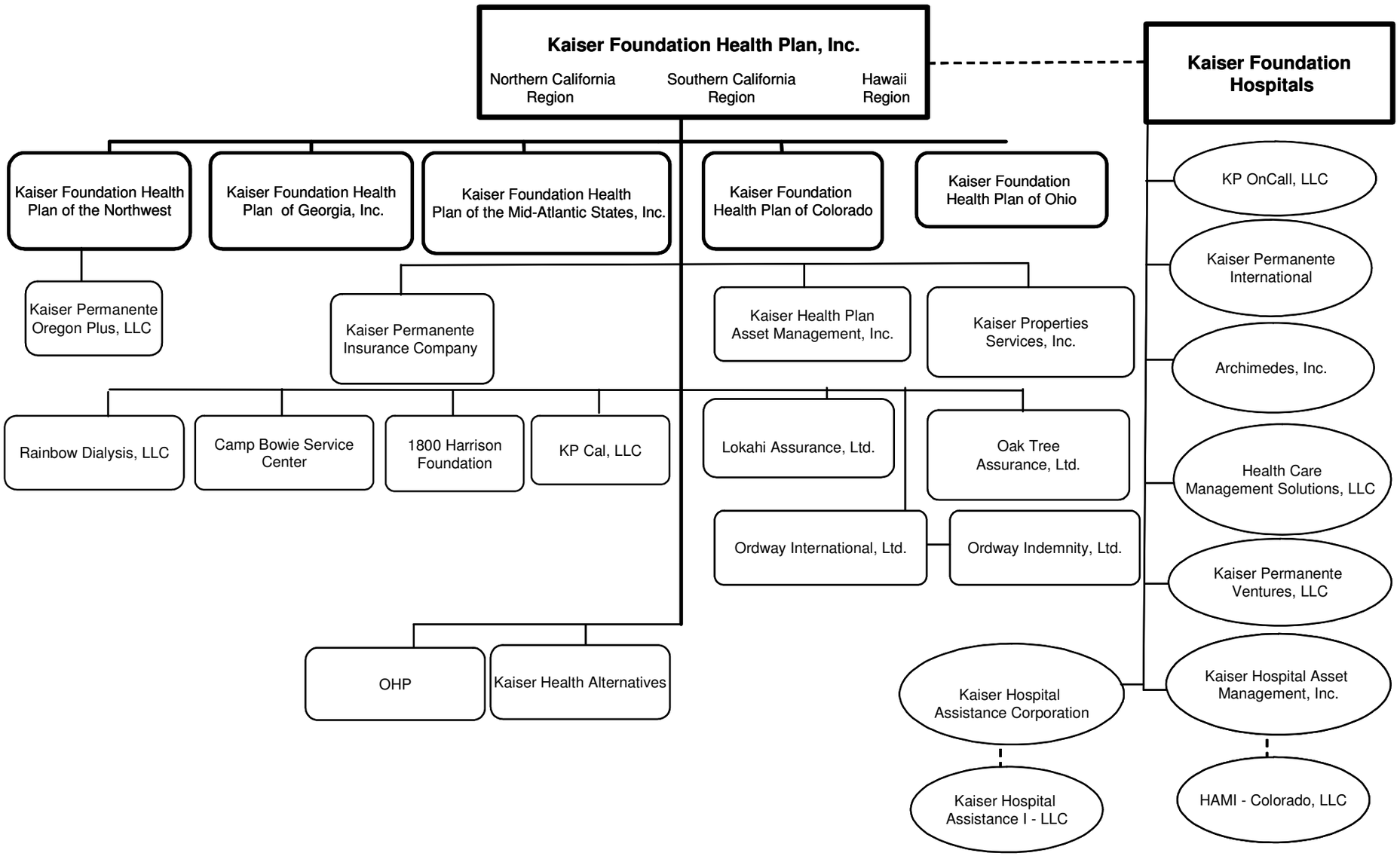
Current Year to Date - Allocated by States and Territories

States, Etc.	1 Active Status	Direct Business Only 2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefit Program Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama AL								0	
2. Alaska AK								0	
3. Arizona AZ								0	
4. Arkansas AR								0	
5. California CA								0	
6. Colorado CO								0	
7. Connecticut CT								0	
8. Delaware DE								0	
9. Dist. Columbia DC								0	
10. Florida FL								0	
11. Georgia GA								0	
12. Hawaii HI	L	284,870,913	159,629,267	29,021,234	32,735,469			506,256,883	
13. Idaho ID								0	
14. Illinois IL								0	
15. Indiana IN								0	
16. Iowa IA								0	
17. Kansas KS								0	
18. Kentucky KY								0	
19. Louisiana LA								0	
20. Maine ME								0	
21. Maryland MD								0	
22. Massachusetts MA								0	
23. Michigan MI								0	
24. Minnesota MN								0	
25. Mississippi MS								0	
26. Missouri MO								0	
27. Montana MT								0	
28. Nebraska NE								0	
29. Nevada NV								0	
30. New Hampshire NH								0	
31. New Jersey NJ								0	
32. New Mexico NM								0	
33. New York NY								0	
34. North Carolina NC								0	
35. North Dakota ND								0	
36. Ohio OH								0	
37. Oklahoma OK								0	
38. Oregon OR								0	
39. Pennsylvania PA								0	
40. Rhode Island RI								0	
41. South Carolina SC								0	
42. South Dakota SD								0	
43. Tennessee TN								0	
44. Texas TX								0	
45. Utah UT								0	
46. Vermont VT								0	
47. Virginia VA								0	
48. Washington WA								0	
49. West Virginia WV								0	
50. Wisconsin WI								0	
51. Wyoming WY								0	
52. American Samoa AS								0	
53. Guam GU								0	
54. Puerto Rico PR								0	
55. U.S. Virgin Islands VI								0	
56. Northern Mariana Islands MP								0	
57. Canada CN								0	
58. Aggregate other alien OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX	284,870,913	159,629,267	29,021,234	32,735,469	0	0	506,256,883	0
60. Reporting entity contributions for Employee Benefit Plans	XXX	8,818,439						8,818,439	
61. Total (Direct Business)	(a) 1	293,689,352	159,629,267	29,021,234	32,735,469	0	0	515,075,322	0
DETAILS OF WRITE-INS									
5801.	XXX								
5802.	XXX								
5803.	XXX								
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
5899. Totals (Lines 5801 through 5803 plus 5898) (Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered – Licensed Insurance Carrier or Domiciled RRG; (R) Registered – Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible – Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above – Not allowed to write business in the state.

(a) Insert the number of L responses except for Canada and other Alien.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 - ORGANIZATIONAL CHART



SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of **NO** to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter **SEE EXPLANATION** and provide an explanation following the interrogatory questions.

	RESPONSE
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1.

Bar Code:

1. 

OVERFLOW PAGE FOR WRITE-INS

MQ002 Additional Aggregate Lines for Page 02 Line 25.
*ASSETS

	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Prior Year Net Admitted Assets
2504. Other long-term assets	429,668	429,668	0	0
2597. Summary of remaining write-ins for Line 25 from Page 02	429,668	429,668	0	0

MQ003 Additional Aggregate Lines for Page 03 Line 23.
*LIAB

	1 Covered	2 Uncovered	3 Total	4 Total
2304. Due to Associated Medical Group	14,280,567		14,280,567	10,142,270
2305. Other Liability	10,598,399		10,598,399	10,064,542
2306. Pension Liability	21,950,672		21,950,672	21,191,776
2397. Summary of remaining write-ins for Line 23 from Page 03	46,829,638	0	46,829,638	41,398,588

SCHEDULE A - VERIFICATION

Real Estate

	1 Year to Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year	108,340,485	112,589,544
2. Cost of acquired:		
2.1 Actual cost at time of acquisition		0
2.2 Additional investment made after acquisition	978,369	1,245,989
3. Current year change in encumbrances		0
4. Total gain (loss) on disposals		0
5. Deduct amounts received on disposals		0
6. Total foreign exchange change in book/adjusted carrying value		0
7. Deduct current year's other than temporary impairment recognized		0
8. Deduct current year's depreciation	2,801,463	5,495,048
9. Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)	106,517,391	108,340,485
10. Deduct total nonadmitted amounts	0	0
11. Statement value at end of current period (Line 9 minus Line 10)	106,517,391	108,340,485

SCHEDULE B – VERIFICATION

Mortgage Loans

NONE

	1 Year to Date	2 Prior Year Ended December 31
1. Book value/recorded investment excluding accrued interest, December 31 of prior year	0	0
2. Cost of acquired:		
2.1 Actual cost at time of acquisition		0
2.2 Additional investment made after acquisition		0
3. Capitalized deferred interest and other		0
4. Accrual of discount		0
5. Unrealized valuation increase (decrease)		0
6. Total gain (loss) on disposals		0
7. Deduct amounts received on disposals		0
8. Deduct amortization of premium and mortgage interest points and commitment fees		0
9. Total foreign exchange change in book value/recorded investment excluding accrued interest		0
10. Deduct current year's other than temporary impairment recognized		0
11. Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	0	0
12. Total valuation allowance		0
13. Subtotal (Line 11 plus Line 12)	0	0
14. Deduct total nonadmitted amounts	0	0
15. Statement value at end of current period (Line 13 minus Line 14)	0	0

SCHEDULE BA – VERIFICATION

Other Long-Term Invested Assets

NONE

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value, December 31 of prior year	0	0
2. Cost of acquired:		
2.1 Actual cost at time of acquisition		0
2.2 Additional investment made after acquisition		0
3. Capitalized deferred interest and other		0
4. Accrual of discount		0
5. Unrealized valuation increase (decrease)		0
6. Total gain (loss) on disposals		0
7. Deduct amounts received on disposals		0
8. Deduct amortization of premium and depreciation		0
9. Total foreign exchange change in book/adjusted carrying value		0
10. Deduct current year's other than temporary impairment recognized		0
11. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	0	0
12. Deduct total nonadmitted amounts	0	0
13. Statement value at end of current period (Line 11 minus Line 12)	0	0

SCHEDULE D – VERIFICATION

Bonds and Stocks

NONE

	1 Year To Date	2 Prior Year Ended December 31
1. Book/adjusted carrying value of bonds and stocks, December 31 of prior year	0	0
2. Cost of bonds and stocks acquired		0
3. Accrual of discount		0
4. Unrealized valuation increase (decrease)		0
5. Total gain (loss) on disposals		0
6. Deduct consideration for bonds and stocks disposed of		0
7. Deduct amortization of premium		0
8. Total foreign exchange change in book/adjusted carrying value		0
9. Deduct current year's other than temporary impairment recognized		0
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	0	0
11. Deduct total nonadmitted amounts	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	0	0

Schedule D - Part 1B

NONE

Schedule DA - Part 1

NONE

Schedule DA - Verification

NONE

Schedule DB - Part A - Verification

NONE

Schedule DB - Part B- Verification

NONE

Schedule DB - Part C - Section 1

NONE

Schedule DB - Part C - Section 2

NONE

Schedule DB - Verification

NONE

Schedule E Verification

NONE

Schedule A - Part 2

NONE

Schedule A - Part 3

NONE

Schedule B - Part 2

NONE

Schedule B - Part 3

NONE

Schedule BA - Part 2

NONE

Schedule BA - Part 3

NONE

Schedule D - Part 3

NONE

Schedule D - Part 4

NONE

Schedule DB - Part A - Section 1

NONE

Sch. DB - Pt. A - Sn. 1 - Footnote (a)

NONE

Schedule DB - Part B - Section 1

NONE

Sch. DB - Pt. B - Sn. 1 - Footnotes

NONE

Schedule DB - Part D

NONE

Schedule DL - Part 1

NONE

Schedule DL - Part 2

NONE

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of Hawaii - CD	Hawaii	0.250			150,000	150,000	150,000	XXX
Bank of Hawaii - CD	Hawaii	0.250	92		150,000	150,000	150,000	XXX
Bank of Hawaii	Hawaii				20,248,823	4,808,706	2,855,551	XXX
First Hawaiian Bank	Hawaii				283,379	382,034	252,811	XXX
CitiBank	Delaware				(5,610,461)	(6,324,660)	(6,232,151)	XXX
CitiBank	Delaware				(132,741)	(85,523)	(99,481)	XXX
Bank of America	North Carolina				200,617	129,849	133,603	XXX
0199998 Deposits in 5 depositories that do not exceed the allowable limit in any one depository (see Instructions) - Open Depositories	XXX	XXX			1,000	1,000	1,000	XXX
0199999 Totals - Open Depositories	XXX	XXX	92		15,290,617	(788,594)	(2,788,667)	XXX
0399999 Total Cash on Deposit	XXX	XXX	92		15,290,617	(788,594)	(2,788,667)	XXX
0499999 Cash in Company's Office	XXX	XXX	XXX	XXX	54,825	60,175	60,875	XXX
0599999 Total	XXX	XXX	92		15,345,442	(728,419)	(2,727,792)	XXX

Schedule E - Part 2 - Cash Equivalents

NONE

KAISER PERMANENTE®

2010 Kaiser Permanente Certification
Management's Report of Internal Control over Financial Reporting

Completed by:
Program Level Executives: CEO, CFO

Stating the following:

Management of Kaiser Foundation Health Plan, Inc. - Hawaii Region (the Company) is responsible for establishing and maintaining adequate internal control over statutory financial reporting. The Company has established an internal control system designed to provide reasonable assurance regarding the fair presentation of statutory financial reporting. Management conducted an assessment of the effectiveness, as of December 31, 2010, of the Company's internal control over statutory financial reporting, based on the framework established in the *Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)*. Based on our assessment under that framework, and to the best of management's knowledge and belief, after diligent inquiry, management has concluded that the Company's internal control over statutory financial reporting is effective to provide reasonable assurance regarding the reliability of financial reporting and the preparation of statutory financial statements as of December 31, 2010.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are also subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on management review of internal controls, there were no unremediated material weaknesses as of December 31, 2010 identified as part of the Company's internal control structure over the statutory financial statements for the year ended December 31, 2010.

Date: 6-22-11

George C Halvorson
Chairman and Chief Executive Officer

Date: 6/22/11

Kathy Lancaster
Executive Vice President and Chief Financial Officer

Controlling Interest Form

The applicant must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the applicant's proposal as unresponsive.

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No
Not applicable				

Operational Certification Submission Form

The applicant must complete the attached certification as documentation that it shall maintain member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rules or policies and procedures.

By signing below the applicant certifies that it shall at all times during the term of this contract provide and maintain member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The applicant warrants that in the event DHS discovers, through an operational review, that the applicant has failed to maintain these operating procedures, the applicant will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

J. Daniels — November 28, 2011

Signature **Date**

Grievance System Form

The applicant must complete the form below and submit with this proposal.

I hereby certify that Kaiser Foundation Health Plan, Inc.
Applicant Name

will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with OHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the applicant must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the applicant. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by OHS and deficiencies are subject to sanction in accordance with OHS rules.

Joan Danieley
Authorized Signature

November 18, 204
Date

Joan Danieley
Printed Name

VP-Health Plan Admin.
Title

Insurance

Applicant shall provide the following:

1. Commercial General Liability Insurance is provided by:
   Insurance Company: Self Insured
   Coverage: $3 million per occurrence

2. Automobile Insurance is provided by:
   Insurance Company: Marsh Risk & Insurance Services
   Coverage: $1 million per occurrence

3. Worker's Compensation/Employers Liability is provided by:
   Insurance Company: Marsh Risk & Insurance Services
   Coverage: $5 million per occurrence

4. Other Insurance to include reinsurance or professional liability
   Type: Hospital/Physician Liability Insurance
   Insurance Company: Self Insured
   Coverage: $3 million per occurrence

   Type: _____
   Insurance Company: _____
   Coverage: _____
   Type: _____
   Insurance Company: _____
   Coverage: _____

Kaiser Foundation Health Plan, Inc.
Applicant

Wage Certification

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract in excess of $25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid as wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.

2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required *by* Federal and Stale laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, HRS.

Applicant: Kaiser Foundation Health Plan, Inc.
Signature: [signature]
Title: Vice President Health Plan Service + Administration
Date: November 28, 2011

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of:

Kaiser Foundation Health Plan, Inc.
(Name of PROVIDER)

PROVIDER, the undersigned does declare as follows:

1. PROVIDER ☐ is* ☒ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).

2. PROVIDER has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).

3. PROVIDER has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).

4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

PROVIDER understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawai'i Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the

* Reminder to agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract may not be awarded unless the agency posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

PROVIDER

By J Danieley (Signature)

Print Name Joan Danieley

Print Title Vice President Health Plan Service + Administration

Date November 28, 2011

HCE

FORM A-6
(REV. 2010)

STATE OF HAWAII — DEPARTMENT OF TAXATION

TAX CLEARANCE APPLICATION

PLEASE TYPE OR PRINT CLEARLY

Form A-6 can be filed electronically. See instructions.

FOR OFFICE USE ONLY

BUSINESS START DATE IN HAWAII IF APPLICABLE: 12/01/1958

HAWAII RETURNS FILED IF APPLICABLE

20____ 20____ 20____

____ ____ ____

STATE APPROVAL STAMP (Not valid unless stamped)

State of Hawaii
APPROVED
MAR 16 2011
per
Department of Taxation

*IRS APPROVAL STAMP

INTERNAL REVENUE SERVICE
APPROVED
Honolulu
MAR 28 2011
per
W & I Area Terr.

CERTIFIED COPY STAMP

This copy is acceptable as a substitute for the original tax clearance certificate issued.
Internal Revenue Service

1. APPLICANT INFORMATION: (PLEASE PRINT CLEARLY)

Applicant's Name: KAISER FOUNDATION HEALTH PLAN INC

Address: 711 KAPIOLANI BLVD.

City/State/Postal/Zip Code: HONOLULU, HI 96813

DBA/Trade Name: KAISER PERMANENTE

2. TAX IDENTIFICATION NUMBER:

HAWAII TAX ID # W ____ ____ ____ ____ ____ ____ ____ ____ - ____ ____

FEDERAL EMPLOYER ID # (FEIN): 9 4 - 1 3 4 0 5 2 3

SOCIAL SECURITY # (SSN): ____ ____ ____ - ____ ____ - ____ ____ ____ ____

3. APPLICANT IS A/AN: (MUST CHECK ONE BOX)

- ☐ CORPORATION
- ☐ S CORPORATION
- ☑ TAX EXEMPT ORGANIZATION
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ ESTATE
- ☐ TRUST
- ☐ LIMITED LIABILITY COMPANY
- ☐ LIMITED LIABILITY PARTNERSHIP
- ☐ Single Member LLC disregarded as separate from owner; enter owner's FEIN/SSN _____
- ☐ Subsidiary Corporation; enter parent corporation's name and FEIN _____

4. THE TAX CLEARANCE IS REQUIRED FOR: (MUST CHECK AT LEAST ONE BOX)

- ☑ CITY, COUNTY, OR STATE GOVERNMENT CONTRACT IN HAWAII *
- ☐ LIQUOR LICENSE *
- ☐ REAL ESTATE LICENSE
- ☐ CONTRACTOR LICENSE
- ☐ BULK SALES**
- ☐ FINANCIAL CLOSING
- ☐ PROGRESS PAYMENT
- ☐ PERSONAL
- ☐ HAWAII STATE RESIDENCY
- ☐ FEDERAL CONTRACT
- ☐ LOAN
- ☐ SUBCONTRACT
- ☐ OTHER _____

** IRS APPROVAL STAMP IS ONLY REQUIRED FOR PURPOSES INDICATED BY AN ASTERISK.*

*** ATTACH FORM G-8A, REPORT OF BULK SALE OR TRANSFER*

5. NO. OF CERTIFIED COPIES REQUESTED: 10

6. SIGNATURE:

SIGNATURE	DATE	TELEPHONE	FAX
	3-9-2011	(510) 271 - 6385	(510) 271 - 2611

PRINT NAME	PRINT TITLE: Corporate Officer, General Partner or Member, Individual (Sole Proprietor), Trustee, Executor
DEBORAH STOKES	SVP, CORPORATE CONTROLLER AND CHIEF ACCOUNTING OFFICER

POWER OF ATTORNEY. If submitted by someone other than a Corporate Officer, General Partner or Member, Individual (Sole Proprietor), Trustee, or Executor, a power of attorney (State of Hawaii, Department of Taxation, Form N-848) must be submitted with this application. If a Tax Clearance is required from the Internal Revenue Service, IRS Form 8821, or IRS Form 2848 is also required. Applications submitted without proper authorization will be sent to the address of record with the taxing authority. UNSIGNED APPLICATIONS WILL NOT BE PROCESSED.

PLEASE TYPE OR PRINT CLEARLY — THE FRONT PAGE OF THIS APPLICATION BECOMES THE CERTIFICATE UPON APPROVAL.

SEE PAGE 2 ON REVERSE & SEPARATE INSTRUCTIONS. Failure to provide required information on page 2 of this application or as required in the separate instructions to this application will result in a denial of the Tax Clearance request.

State of Hawaii

INSURANCE DIVISION

This is to certify that Kaiser Foundation Health Plan, Inc.

has been duly authorized as a HEALTH MAINTENANCE ORGANIZATION

in the State of Hawaii on May 26, 1998

The above named, having complied with the requirements of the law, is hereby authorized to operate, as a health maintenance organization, in the manner provided by law. This Certificate of Authority is valid until terminated by surrender, suspension, revocation, or failure to extend. A new certificate will not be issued upon extension. This certificate shall remain in the possession of the health maintenance organization named herein until termination, at which time it will be delivered to the Insurance Commissioner.

Insurance Commissioner

Certificate Number 116675

Search Results

There were 2 matches to your search !

Please click on the Taxpayer ID button to get the details.

Taxpayer ID	Name	Business Location	Former Taxpayer ID	Tax Type	Status
W20214476-01	KAISER FNDTN HEALTH PLAN INC	1 KAISER PLZ # 15L Oakland, CA 94612-3610	10002981	General Excise and Use	Open
W20214476-01	KAISER FNDTN HEALTH PLAN INC	1 KAISER PLZ # 15L Oakland, CA 94612-3610	10002981	Withholding	Open

<-Back New Search->

Last Updated on 11/30/2011

Department of Commerce and Consumer Affairs

CERTIFICATE OF GOOD STANDING

I, the undersigned Director of Commerce and Consumer Affairs of the State of Hawaii, do hereby certify that

KAISER FOUNDATION HEALTH PLAN, INC.

incorporated under the laws of California

was duly registered to do business in Hawaii as a foreign nonprofit corporation on 02/24/1958 , and that, as far as the records of this Department reveal, has complied with all of the provisions of the Hawaii Nonprofit Corporation Act, regulating foreign nonprofit corporations.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of the Department of Commerce and Consumer Affairs, at Honolulu, Hawaii.

Dated: August 05, 2006

Mark E. Rechtenwald

Director of Commerce and Consumer Affairs

To check the authenticity of this certificate, please visit: http://hbe.ehawaii.gov/cogs/authenticate.html
Authentication Code: 4122-695-P2

XRBC

Company Code 11538

Kaiser Foundation Health Plan, Inc.
Hawaii Region

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount
(1)	Total Adjusted Capital, Post-Tax		131,996,801
(2)	Company Action Level = 200% of Authorized Control Level	CAL	31,439,498
(3)	Regulatory Action Level = 150% of Authorized Control Level	RAL	23,579,624
(4)	Authorized Control Level = 100% of Authorized Control Level	ACL	15,719,749
(5)	Mandatory Control Level = 70% of Authorized Control Level	MCL	11,003,824
(6)	Level of Action, if Any	NONE	

THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE

Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page 131,996,801

Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page 15,719,749

TREND TEST:

(7)	Total Revenue	Page 4, Line 8	957,012,932	
(8)	Underwriting Deductions	Page 4, Line 23	967,729,771	
(9)	Combined Ratio	Line (8)/Line (7)	101.120	
(10)	RBC Ratio	Line (1)/Line (4)	839.688	
(11)	Trend Test Result	If Line (10) is between 200% and 300% and Line (9)> 105%, then "Yes", otherwise "No"		NO
(12)	Level of Action, if any, including Trend Test		NONE	

XR025

KAISER PERMANENTE®

Section 80.300

Technical Proposal

80.310 Experience and References (12 pages maximum not including attachments B, C, E, and F below)

The applicant shall provide:

A. A narrative of its experience providing services to Medicaid populations in Hawaii and in other States. As part of this narrative, please indicate specific enrollment numbers if not provided elsewhere in Section 80.310. Also as part of this narrative the applicant may include experience of an affiliated company, a company with the same parent company as the applicant, and any subcontractors who will be providing direct services and that the applicant intends to use in the QUEST program;

Kaiser Permanente is one of America's leading integrated health care organizations. Founded in 1945, it is a non-profit, group-practice prepayment program with headquarters in Oakland, California. Today it encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Groups, as well as an affiliation with the Seattle-based Group Health Cooperative. Nationwide, Kaiser Permanente includes over 167,000 technical, administrative and clerical employees and almost 16,000 physicians representing all specialties.

Kaiser Permanente serves the health care needs of 8.7 million members in nine states and the District of Columbia. Services to the Medicaid population in seven states are provided through 18 Medicaid contracts which serve over 400,000 lives. For a detailed list of contracts, see item B in this section.

Kaiser Permanente is also the largest and most experienced group model health maintenance organization in the State of Hawaii. Operating in Hawaii since 1958, Kaiser Permanente now serves more than 229,000 members. Kaiser Permanente Hawaii provides clinical care services in its own medical clinics on three islands: Hawaii (4); Maui (4), and Oahu (11). On Kauai, Molokai, and Lanai, members are cared for in private offices of a preferred provider network. On Oahu, there is one Kaiser Foundation Hospital (Moanalua Medical Center) with 278 beds and a skilled care facility. Additionally, we contract for care services with 23 acute care hospitals on all islands for inpatient services. The Hawaii Permanente Medical Group consists of 438 physicians. 90.7% of primary care physicians and 90.8% of physician specialists are board certified.

For 40 years Kaiser Permanente Hawaii has had a program of medical care and outreach service for persons with low income. The program began in 1971 with the enrollment of 500 public assistance families under a contract with the Hawaii Department of Human Services called X5. It continued with federal and state contracts for medical care for families with low-to-moderate income who were not eligible for public assistance.

In August 1994, when the State of Hawaii implemented the Hawaii QUEST program (QUEST), Kaiser Permanente initially participated only on the island of Oahu. In 1996, Maui was added. Currently, over 27,000 QUEST members are enrolled in Kaiser Permanente's QUEST program on the islands of Oahu and Maui. Some enrollees receive public assistance; others have low or moderate income but no insurance through employment.

QUEST members have access to all the benefits of a fully integrated and coordinated delivery system with aligned incentives to provide prevention services, chronic disease management, and other medical and behavioral health care services. QUEST members also receive the services of a case management team (consisting of nurses and paraprofessional staff) who monitors compliance with health screening of children and youth, identifies the needs of those who are at high risk, provides health education, visits homebound members, arranges emergent and non-emergent transportation when medically necessary, makes referrals to community agencies, and advocates for the members.

NCQA recently recognized Kaiser Permanente Hawaii's QUEST Program as the #2 Medicaid health plan in the nation for 2011-2012, retaining its position from the previous year. Kaiser Permanente was also the first plan in the State of Hawaii to receive full three-year accreditation by the National Committee for Quality Assurance (NCQA) and is the only health care organization to receive the State Award for Excellence. As a non-profit HMO, Kaiser Permanente is firmly committed to the community and also has a long history of participating in charitable activities both directly and indirectly.

See attached 2010 "Kaiser Permanente Hawaii Region Community Benefit Report".

B. A listing, in table format, of contracts for all Medicaid program clients (including those served by an affiliated company or a company with the same parent company as the applicant, and any subcontractors that are or have provided direct services and that the applicant intends to use in the QUEST program), past and present. This listing shall include the name, title, address, telephone number and e-mail address of the client and/or contract manager, the number of individuals the applicant has managed broken down by the type of membership (e.g. TANF and TANF related, foster children, aged, blind, disabled, etc.), and the number of years the applicant has been providing or had provided services for that program. In the interest of space, if the applicant has ten (10) or more contracts for the Medicaid programs that entail the provision of direct services, it is not necessary to include all contracts which do not entail direct service provision (e.g., administrative service arrangements);

See attached "Contracts for Medicaid Programs".

C. Letters of recommendation that support the health plan's proposal. The health plan shall submit no more than ten (10) letters of recommendation. Letters of recommendation may be provided from: (1) member advocacy groups in the State or service region; (2) provider organizations in the State or service region; or (3) other persons or organizations that have had an opportunity to work with the health plan and can recommend their work in the QUEST program;

NCQA recently recognized Kaiser Permanente Hawaii's QUEST Program as the #2 Medicaid health plan in the nation for 2011-2012, retaining its position from last year. The

NCQA Review Oversight Committee also awarded Kaiser Permanente Hawaii's QUEST Program with an excellent accreditation status for 2010.

See attached Letters of Recommendation.

D. Information on: (1) whether or not any applicant contract (including those for an affiliate of the company, a company with the same parent company as the applicant, or any subcontractor that the applicant intends to use in the QUEST program to provide direct services) has been terminated or not renewed for non-performance or poor performance within the past five (5) years; and (2) whether the applicant (including an affiliate of the company, a company with the same parent company as the applicant or any subcontractor providing direct services) failed to complete a full contract term or self-terminated mid-contract. Please include information on the details of the termination, non-renewal, failure to complete a full contract term or self-termination;

Neither Kaiser Foundation Health Plan, Inc. nor any affiliated company has ever failed to complete a full contract term, self-terminated mid-contract, or been terminated or not renewed for non-performance or poor performance of a Medicaid contract.

E. Its most recent EQRO evaluations (July 2011) from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent EQRO evaluation from at least two other states in which it has previously been or is currently operating. Note: this shall be cross-checked with references to ensure all EQROs have been submitted. The EQRO evaluations do not count towards the page limit; and

See attached "2011 External Quality Review of Compliance with Standards for Kaiser Permanente QUEST Health Plan".

F. EPSDT measures for the last twelve (12) month period from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State

of Hawaii, the applicant shall submit its most recent EPSDT measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on and include geographic location and member demographics. The applicant shall indicate that measures were validated by an EQRO and provide the EQRO validation reports. Note: neither the EPSDT measures nor the EQRO validation reports count towards the page limit.

See attached documents:

- HEDIS 2010
- HEDIS 2010 Compliance Audit Final Report of Findings for Kaiser Permanente QUEST, July 2010
- HEDIS 2011
- HEDIS 2011 Compliance Audit Final Report of Findings for Kaiser Permanente Hawaii QUEST, July 2011
- Form CMS 416: Annual EPSDT Participation Report 2010

KAISER PERMANENTE HAWAII REGION
COMMUNITY BENEFIT REPORT
2010

Aloha,

As a kama'aina company and a trusted member of Hawaii's community since 1958, Kaiser Permanente is proud to share strong local values and play a fundamental role in improving the lives of the people of Hawaii.

Total health begins in our own communities, because good health starts where we live, work, and play. That's why Kaiser Permanente is so passionately committed to reaching out to local communities in need, educating our island families about health, wellness, and prevention, and providing meaningful and much-needed support to Hawaii's most vulnerable populations.

TOGETHER WE CAN MAKE A DIFFERENCE

This report covers just some of our Community Benefit activities from 2010. We hope it gives you a better idea of who we are and what we stand for. It also highlights the incredible work of our valued community partners.

We would like to thank our public servants and community leaders for supporting Kaiser Permanente's team of physicians and staff to champion health services for our island community. Together, we're building healthier lives and much stronger communities for all of Hawaii.

Sincerely,

Janet Liang
President
Kaiser Permanente Hawaii

Geoffrey Sewell, MD
Executive Medical Director
Hawaii Permanente Medical Group

A HISTORY OF **COMMUNITY SUPPORT**

For half a century, Kaiser Permanente has been actively involved in our local communities, and 2010 was no exception. In a year that saw some of the highest unemployment rates in the past two decades, we hired nearly 400 local residents and provided $10 million in medical financial assistance to residents in need.

We encouraged healthy eating and supported local farmers by hosting year-round, weekly farmers' markets at three of our facilities. Our environment is healthier and our landfills are emptier because we reprocessed 4.9 tons of medical products rather than disposing of them.

These efforts are rooted in Kaiser Permanente's mission to provide affordable, high quality health care services and to improve the health of our members and **the communities we serve.** To help fulfill our mission, our Community Benefit program works with community partners to achieve the following goals:

- Ensure that low-income families get the care and coverage they need
- Work with community health care providers to help them expand services and improve care
- Improve community health by aiding efforts to change policy, organizational practices, and the environmental conditions that influence health
- Conduct and share groundbreaking medical research with the public

Through Community Benefit, we are working together with our community partners to improve the health of Hawaii and its people.

GIVING OUR STATE **A SHARED VOICE**

To assist with delivering on our mission, we commissioned *Community Voices on Health*, the first needs assessment completed for the entire state of Hawaii. Much more than a statistical report, *Community Voices on Health* combines the input and knowledge of health care experts, policy makers, and 150 community members from 10 community-based listening sessions conducted at sites on Oahu, Maui, and the Big Island. We paired this blend of perspectives with statistical data to provide a more complete picture of health in our state.

The report covers the following key areas:

- Hawaii's overall demographics
- The health status, health disparities, and gaps in health care services in communities across the state
- Trends in social and economic determinants in health

Kaiser Permanente is sharing *Community Voices on Health* with stakeholders in the healthcare industry, community, and state government to lead a multifaceted approach toward dealing with health disparities in Hawaii.

OUTREACH WITH **LASTING IMPACT**

No amount of words can give proper due to the work of our 29 partners in the community, but we are honored to highlight a few of their initiatives here.

LOCALLY ONO, HEALTH PONO

In a time when Hawaii imports approximately 85 percent of its food, Kaiser Permanente Hawaii is committed more than ever toward improving our islands' self-sufficient food systems and supporting local agriculture. We've aided some wonderful organizations that share our belief that promoting sustainable, local food systems is essential for the health of Hawaii's communities:

The Hawaii Food Policy Council, funded in part by the State of Hawaii Office of Community Services, promotes nutritious diets and sustainable food systems through program development, research, and advocacy.

"The support we received from Kaiser will take our efforts to the next level by assisting us in reaching out to the industries everyone in the food conversation takes for granted, such as distributors and warehousers."

~En Young, State of Hawaii, Office of Community Services Program Specialist

Kokua Hawaii Foundation's Aina in Schools program works with 10 Oahu schools on environmental stewardship, childhood obesity prevention, and efforts to link Hawaii's farmers to institutional markets.

"It connects them with the farmers, with the idea of growing food here in Hawaii and that's the long term goal — getting them to support local agriculture and getting them to shop local."

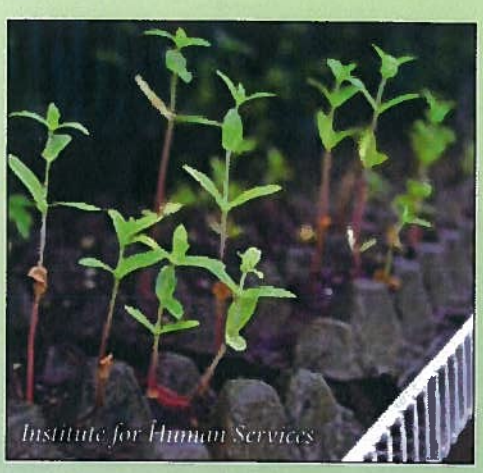
~Jack Johnson, Singer-Songwriter and Kokua Hawaii Foundation Co-Founder

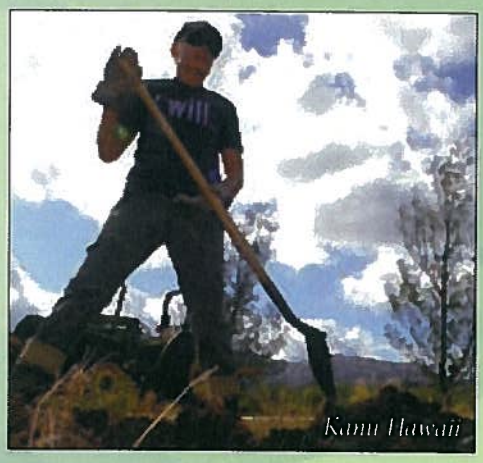
Kanu Hawaii's "Eat Local Challenge" utilizes its strong social media presence of 13,000 online followers and its partners of more than 50 businesses in the community to ask residents across the state to eat only locally grown and harvested food.

The Institute for Human Services' edible gardening initiative provides vocational training to those it serves and improves the nutritional value of 600 daily meals at its Women's and Family Shelter.

"I can't say it enough, how thankful I am to get this training because of your sponsorship. It opened a new world and a new phase in my life. I'm so fortunate that I'm doing what I want to do. Thank you!"

~Dulcie Marchant, IHS Edible Gardens Program Graduate





TEENS THRIVE IN THE SPOTLIGHT

Kapolei High School and **Castle High School** both participate in our Educational Theatre Program, which uses live theatre to deliver powerful messages about healthy eating and active living to more than 6,000 students in 22 schools.

"Thank you so much for blessing us with the play. Our school appreciates it and would love to have you back for more... If you ever lose funding, we would pay a fee to see that kind of production again!"

~ Mokapu Elementary School Teacher

CARE FOR OUR KUPUNA

Kula no na Po'e Hawaii is a culturally appropriate program that coordinates social work and public health master's degree students to provide case management and care delivery to 50 kupuna in the underserved Papakolea community.

Educational Theatre Program

OUTREACH TO THE UNDERSERVED

Life Foundation's outreach initiative will address health disparities among the underserved Native Hawaiian population by providing 500 Native Hawaiians with HIV prevention, case-management, and care delivery.

"Because of our program, the HIV positive Native Hawaiian community has a voice. We are grateful for Kaiser Permanente's support of this important work."

~ Raymond Alejo, Life Foundation HIV Care Nurse

BEYOND **COMMUNITY BENEFIT**

Kaiser Permanente touches many lives in Hawaii through our organization-level efforts and through the personal contributions of our workforce. Below are a few numbers highlighting our diversity and community contributions that go beyond our Community Benefit program.

- 25,750 QUEST members enrolled
- 161 uninsured individuals benefited from charitable coverage
- 223 statewide child safety inspections conducted
- 727 trained to fill healthcare workforce shortages
- Nearly 70 community organizations supported by Community Benefit and Community Relations
- 71 percent of our non-physician workforce is Asian or Pacific Islander

WE **VOLUNTEER**

Nearly 350 KP physicians and staff gave their time on Martin Luther King, Jr. Day for Community Service Day on Oahu, Maui, and the Big Island.

We had 318 KP physicians and staff volunteer their time for the 2010 Great Aloha Run Sports, Health & Fitness Expo, which had about 39,000 visitors. The Great Aloha Run saw a total of 24,710 registrants with 145 KP volunteers giving their time to staff the finish line aid stations.

LOOKING **AHEAD**

As we continue forward in 2011, our priorities are unwavering. The challenges Hawaii saw in 2010 are still with us, but we stand firm with our communities. The responsibilities to our neighbors in need and to our environment fall upon everyone's shoulders. Together, we can move forward and work toward a healthier Hawaii.

KAISER PERMANENTE®

2010 Grant and Donation Recipients

Aloha United Way
American Cancer Society
Bay Clinic (Hilo)
Castle High School Performing Arts Center
Goodwill Industries of Hawaii
Hawaii County Healthcare Conference
Hawaii Farm Bureau Foundation for Agriculture
Hawaii Foodbank
Hawaii Health Information Exchange (HHIE)
Hawaii Primary Care Association
Institute for Human Services (IHS)
Kanu Hawaii
Kapolei High School Performing Arts Center
The Kohala Center
Kokua Hawaii Foundation
Kula no na Po'e Hawaii
Lahaina High School Health Occupations Students of America Club
Lanakila Rehab Center
Life Foundation
Maui Foodbank
Maui United Way
North Kohala Community Resource Center
Olomana High School
Parents and Children Together (PACT)
Special Olympics Hawaii, Inc.
State of Hawaii, Office of Community
UH Foundation
University of Hawaii JABSOM
YMCA of Honolulu

KAISER PERMANENTE®

State	Name/Title	Address	Telephone Number	Email Address	# of Individuals by Type	# of Yrs Providing Services	Has contract been terminated or not renewed d/t poor performance? (YES/NO)	Has the applicant failed to complete full term of contract or self-terminated mid-contract? (YES/NO)
CA	Robert Lucia	Department of Health Care Services	916-319-8517	Robert.Lucia@dhcs.ca.gov	GMC Sacramento - 28,144	17	No	No
	Contract Manager	Commercial Plan Unit	916-449-5090		GMC San Diego - 13,848	17	No	No
		Plan Management Branch						
		Medi-Cal Managed Care Division						
		1501 Capitol Avenue						
		Sacramento, CA 95814						
CA	Janette Casillas	Manged Risk Medical Insurance Board	916-324-4695	jlopez@mrmib.ca.gov	SCHIP: 184,181	14	No	No
	Executive Director	1000 G Street, Suite 450						
		Sacramento, CA 95814						
	Subcontracted Plan Partners							
CA	Ingrid Lamirault	Alameda Alliance for Health	510-747-4500	Ilamirault@alamedaalliance.org	MCMC: 13,134	10	No	No
		1240 South Loop Road						
		Alameda, CA 94502						
CA	Patricia Tanquary	Contra Costa Health Plan	925-313-6004	ptanquary@hsd.cccounty.us	MCMC: 10,604	6	No	No
		595 Center Avenue, Suite 100						
		Martinez, CA 94553						
CA	Maya Altman	Health Plan of San Mateo	650-616-0050	maya.altman@hpsm.org	MCMC: 16	2	No	No
		701 Gateway Blvd., Suite 400						
		South San Francisco, CA 94080						
CA	Jack Horn	Partnership Health Plan	800-863-4155	jhorn@partnershiphp.org	MCMC Napa/Solano: 14,591	4	No	No
		360 Campus Lane, Suite 100			MCMC Marin: 1,081			
		Fairfield, CA 94534			MCMC Sonoma: 6,799			
CA	John F. Grgurina, Jr.	San Francisco Health Plan	415-547-7818	jgrgurina@sfhp.org	MCMC: 2,984	14	No	No
		201 3rd Street, 7th Floor						
		San Francisco, CA 94103						
CA	Elizabeth Darrow	Santa Clara Family Health Plan	408-837-2000	edarrow@scfhp.com	MCMC: 8,159	12	No	No
	CEO	210 Hacienda Ave						
		Campbell, CA 95008						
CA	Howard Kahn	LA Care Health Plan	213-694-1250, ext 4151	hkahn@lacare.org	MCMC: 55,620	14	No	No
	CEO	1055 West 7th Street						
		Los Angeles, CA 90017						
CA	Dr. Brad Gilbert	Inland Empire Health Plan	909-890-2010	gilbert-b@iehp.org	MCMC: 19,370	13	No	No

State	Name/Title	Address	Telephone Number	Email Address	# of Individuals by Type	# of Yrs Providing Services	Has contract been terminated or not renewed d/t poor performance? (YES/NO)	Has the applicant failed to complete full term of contract or self-terminated mid-contract? (YES/NO)
	CEO	303 E. Vanderbilt Way						
		San Bernardino, CA 92408						
CA	Richard Chambers	Cal Optima	714-246-8570	rchambers@caloptima.org	MCMC: 9,982	16	No	No
	CEO	1120 West La Veta Avenue						
		Orange, CA 92868						
CO	**Medicaid**							
	Kathleen Newberg	Managed Care Benefits Section	303.866.3440	Kathleen.Newberg@state.co.us	Medicaid: 10,327	19	No	No
	Primary Care Provider Program Contract Manager	Department of Health Care Policy & Financing						
		1750 Grant St.						
		Denver, CO 80203						
	CHIP							
	Teresa Craig	Child Health Plan Plus (CHP+) Section	303.866.3586	Teresa.craig@state.co.us	CHIP: 4,612	13	No	No
	CHP+ HMO Contract Manager	Department of Health Care Policy & Financing						
		1750 Grant St.						
		Denver, CO 80203						
					CO TOTAL: 14,939			
HI	Patti Bazin	Department of Human Services	808-692-8083	pbazin@medicaid.dhs.state.hi.us	TANF: 11,748	17	No	No
	Health Care Services Branch Administrator	Med-QUEST Division			Foster Care: 465			
		601 Kamokila Blvd.			GA: 260			
		Kapolei, HI 96707			QUEST (Waiver): 8,944			
					SCHIP: 3,312			
					Immigrant Preg Woman: 11			
					Expand: 637			
					QUEST-Net Adult: 1,622			
					QUEST-Net Children: 82			
					BHH: 3			
					TOTAL: 27,084			
GA	Andre Payne	Amerigroup Community Care*	678-587-4860	apayne1@amerigroupcorp.com	Medicaid: 2,789	1	No	No
	VP, Provider Network Mgt - GA	303 Perimeter Center North, Suite 400			PeachCare (CHIP):470			
		Atlanta, GA 30346			TOTAL: 3,259			

State	Name/Title	Address	Telephone Number	Email Address	# of Individuals by Type	# of Yrs Providing Services	Has contract been terminated or not renewed d/t poor performance? (YES/NO)	Has the applicant failed to complete full term of contract or self-terminated mid-contract? (YES/NO)
		**The Georgia region participates in Medicaid as a sub-contractor to Amerigroup Community Care due to geographic restrictions*						
MAS	Ray Rooks	Priority Partners	410-424-4867	rrooks@jhhc.com	Medicaid &CHIP: 684	2	No	No
	Network Manager	*Johns Hopkins HealthCare LLC*						
	Provider Relations	6704 Curtis Court						
		Glen Burnie, MD 21060						
OH	Laverne Willis	CareSource	216-896-8161	Laverne.Willis@caresource.com	Medicaid: 860	2.5	No	No
	Provider Relations Representative	3659 Green Road, Suite 220						
		Cleveland, OH 44122						
OR	Judy Mohr-Peterson	Division of Medical Assistance Programs	503-945-5768	judy.mohr-peterson@state.or.us	Medicaid & SCHIP: 6,192	34	No	No
	Director, Div. of Medical Assistance Programs	500 Summer St., NE E49						
		Salem, OR 97301-1079						

State of Hawaii

Department of Human Services
Med-QUEST Division

2011 External Quality Review of Compliance With Standards *for* Kaiser Permanente QUEST Health Plan

July 2011

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

Background

State Medicaid and licensing agencies, private accreditation organizations, and the federal Medicare program all recognize that having standards is only the first step in promoting safe, accessible, timely, and quality services. The second step is ensuring compliance with the standards.

The Code of Federal Regulations (CFR) at 42 CFR 438.358 describes activities related to required external quality reviews, the state Medicaid agency, its agent that is not a Medicaid managed care organization (MCO) or prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO), must conduct a review within each three-year period to determine the MCOs' and PIHPs' compliance with State standards. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. The State of Hawaii, Department of Human Services, Med-QUEST Division (MQD), contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to:

- Conduct the compliance reviews for each of its five MCOs.
- Prepare a report of findings with respect to each organization's performance strengths and areas requiring corrective action to improve performance related to the quality and timeliness of, and access to, the care and services they provide.
- Conduct a follow-up reevaluation of any MCOs that require implementation of corrective actions in order to attain full compliance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR 438.352(b) and (c). HSAG has extensive experience and expertise in conducting reviews to evaluate MCO and PIHP compliance with the Medicaid managed care regulations and associated state contract requirements. HSAG uses the information and data it derives from the reviews to reach conclusions and make recommendations about the quality and timeliness of, and the access to, care and services the State's MCOs and PIHPs provide.

The MQD has subcontracted with three MCOs designated as the QUEST health plans, and two additional MCOs that are the QUEST Expanded Access (QExA) health plans. The three QUEST health plans provide Medicaid-covered primary and acute physical health and behavioral health services to enrolled members. The QExA health plans serve Medicaid members who are aged, blind, or disabled, and provide primary, acute, and long-term care services and supports.

Description of the 2011 External Quality Review of Compliance With Standards

For this review, the second year of a three-year cycle, HSAG performed a desk review of documents and an on-site review that included reviewing additional documents and conducting interviews with **Kaiser Permanente QUEST Health Plan**'s (**Kaiser**'s) key staff members. HSAG

evaluated the degree to which **Kaiser** complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to the structure and operations standards in 42 CFR 438, Subpart D. The five standards included requirements that addressed the following areas:

- Delegation subcontracts and the health plan's provision of adequate oversight of any delegated managed care functions
- Content, format, and procedures related to the health plan's provision of member information
- The health plan's administration of its grievance system, including processing of grievances and appeals
- Provider subcontracts and the health plan's procedures for selecting providers
- The health plan's procedures for credentialing and recredentialing of its providers

Following each review, HSAG prepared an initial draft report of its findings and forwarded it to the MQD and **Kaiser** for their review prior to issuing the final report. The following sections of this report and its appendices include:

- A summary of HSAG's findings with regard to **Kaiser**'s performance results, strengths, and areas requiring corrective action.
- A description of the process and timeline **Kaiser** must follow for submitting to the MQD its corrective action plan addressing any requirements for which HSAG scored **Kaiser**'s performance as either partially complying or not complying.
- The completed compliance with standards review tools HSAG used to:
  - Structure its evaluation of **Kaiser**'s performance in complying with each of the requirements contained within the five standards and three record reviews.
  - Document its findings, the scores it assigned to **Kaiser**'s performance, and when applicable, any corrective actions required to bring **Kaiser**'s performance into compliance with the requirements.
- The dates of the on-site review and a list of HSAG reviewers and other individuals attending the review, including **Kaiser**'s staff members who participated in the interview and record review sessions.
- A description of the methodology HSAG used to prepare for and conduct the review and to draft its report of findings.
- If applicable, a template for **Kaiser** to document its corrective action plan that must be submitted to the MQD within 30 days of receiving this final report.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG's findings for the 2011 compliance review were determined from its:

- Desk review of the documents **Kaiser** submitted to HSAG prior to the on-site portion of the review.
- On-site activities that included reviewing additional documents and records, as well as interviewing key **Kaiser** administrative and program staff members.

For each of the elements (i.e., requirements) within each standard, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Scored* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the five standards and an overall percentage-of-compliance score across the five standards.

Table 2-1 presents a summary of **Kaiser**'s performance results. The information includes:

- The number of elements that received a score of *Met*, *Partially Met*, or *Not Met*, or a designation of *NA* or *Not Scored*, and the totals across the five standards.
- The total compliance score for each of the five standards.
- The overall compliance score across the five standards.

Details of the scoring methodology are described in Appendix C—Review Methodology.

Table 2-1––Standards and Compliance 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 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.

The remainder of this section describes, for each of the five standards HSAG evaluated, **Kaiser**'s performance strengths and the areas requiring corrective action to bring its performance into compliance with any requirements scored as *Partially Met* or *Not Met*.

Standard I—Delegation

Strengths

This area was not applicable for review as **Kaiser** had no delegated functions related to its QUEST program.

Areas Requiring Corrective Action

None.

Standard II—Member Information

Strengths

Kaiser's member handbook was well written and included the vast majority of member handbook requirements, including an extensive table describing benefits and services. The handbook also included information such as member educational content. Members were informed of their rights in the member handbook, with an explanation of each right, and were reminded of member rights in the member newsletters. Member newsletters also included a comprehensive list of educational classes available to members. Policies and procedures regarding member rights included each of the member rights specified at 42 CFR 438.100. Providers were informed of member rights via the provider manual.

Kaiser's provider directory was organized by island and included all of the required information. **Kaiser** also had a clear process for providing oral translation. The member handbook informed members in 10 languages, including English, that oral translation was available. **Kaiser** also had a clear process for providing materials in other formats and languages.

Areas Requiring Corrective Action

Kaiser's member newsletters did not include the required language block. **Kaiser** must ensure that all member materials include the required language block.

Based on records reviewed on-site, appeal and grievance resolution letters were not all written at or below a 6.9 grade readability level. **Kaiser** must ensure that written grievance and appeal resolution notices are in easily understood language that is at a 6.9 grade reading level or lower.

Kaiser must revise its member materials to include the correct filing time frame for appeals and inform members that they may have a representative, or a provider with written consent, file a grievance on their behalf. The handbook must also include the rules that govern representation at a State administrative hearing.

Standard III—Grievance System

Strengths

Kaiser had a well-defined system for processing member grievances and appeals and an effective tracking mechanism to ensure the timeliness of acknowledgment and resolution notices to members. Records reviewed on-site contained complete documentation of grievance and appeal procedures, the resolution process, and communication with members. Acknowledgment letters for grievances and appeals were personalized to the member's particular issue or appeal. There was evidence in grievance and appeal files that staff provided assistance throughout the grievance or appeal process. Grievances and appeals reviewed were acknowledged within the required time frames. All appeals reviewed were resolved, with notice sent to the member within the required time frame. Appeal resolution letters contained the required content. Members were offered a variety of methods for expressing grievances and filing appeals, including telephone, e-mail, fax, or Let Us Hear From You (LUHFY) forms.

Areas Requiring Corrective Action

Because **Kaiser** did not have an inquiry process as required by the MQD contract, **Kaiser** must develop policies and procedures that describe its inquiry process. **Kaiser** must treat all expressions of dissatisfaction as grievances, sending communication to the member and maintaining documentation and trending of those contacts. If grievances are resolved at the initial point of contact, the acknowledgment and resolution may be contained within the same letter.

During the grievance records review, one of the cases demonstrated that the resolution decision letter was written by the physician about whom the member had complained. **Kaiser** must develop a mechanism to ensure that individuals who make decisions on grievances are not involved in a previous level of review. None of the 10 grievance files reviewed had resolution letters that contained information about the State grievance review process and how to access it. **Kaiser** must ensure that processes and communications for QUEST member grievances include providing members the right to a State grievance review following the internal grievance process.

Kaiser must ensure that its policies and member materials include the fact that member grievances may be filed by a member's representative or a provider, with written permission from the member.

Two of the grievance files and all 10 of the appeal files reviewed on-site had resolution or decision letters that were not at or below a 6.9 grade reading level, and four grievance records did not clearly articulate the resolution or there was no resolution to the grievance. **Kaiser** must ensure that member correspondence regarding grievances and appeals is responsive, clear, and can be easily understood by members.

While the decision to deny, limit, or reduce services is an action, there are other types of actions, and not all decisions are actions. **Kaiser** must revise its applicable documents to specify that an appeal is a request to review an action, as actions are defined at 42 CFR 438.400. **Kaiser** must allow members 30 days following a notice of action to file an appeal and consult with the MQD

regarding the practice of allowing an extended filing time frame in extenuating circumstances. **Kaiser** must develop a mechanism to notify members in their primary language of grievance and appeal resolutions. Also, Kaiser must develop a process to notify the MQD within 24 hours if an expedited appeal has been requested, granted, denied, and/or extended by the health plan (see Section 50.835 of the MQD contract).

Kaiser must revise its policies to include providing notice of expedited resolutions within three business days and to be consistent with the health plan's practice that QUEST members must exhaust the internal appeal process prior to requesting a State administrative hearing or an external review by the insurance commission.

Although **Kaiser** staff reported during the on-site interview that termination, suspension, or reduction of services rarely occurs, **Kaiser** must develop policies and procedures to continue member services (benefits) during an appeal or State administrative hearing if a member requests continuation of benefits and if the required conditions are met. Policies and procedures must also include information about each of the specific requirements should benefits continue during the appeal or State administrative hearing.

Standard IV—Provider Selection

Strengths

The health plan had policies and processes in place to address the required provision of certain member and provider rights, including those related to payment and billing and nondiscrimination. Required language was contained in provider agreements and communicated in member and provider materials.

Kaiser had mechanisms in place to support the education and training needs of providers regarding health plan expectations and operations. The health plan used provider field representatives, Web portal information, newsletters, e-mail broadcasts, grand rounds, and other in-person methods to communicate with staff and providers regarding important health plan information and changes in procedures.

Kaiser had numerous policies and procedures and a compliance program description to address provider and staff training and education, the health plan's core principles, and processes for the internal and external monitoring, investigation, and reporting of fraud, waste, and abuse (FWA).

Areas Requiring Corrective Action

None.

Standard V—Credentialing

Strengths

Kaiser was deemed compliant for the EQRO review of credentialing, as allowed in the MQD's quality strategy approved by the Centers for Medicare & Medicaid Services (CMS). **Kaiser** had achieved full National Committee for Quality Assurance (NCQA) accreditation, meeting the State's policy requirements for credentialing. Therefore, the credentialing review was not duplicated, per 42 CFR 438.360. HSAG received and reviewed the NCQA accreditation report and confirmed that **Kaiser** had no deficiencies in this area.

Areas Requiring Corrective Action

None.

3. Corrective Action Plan Process

Kaiser is required to submit to the MQD a corrective action plan (CAP) addressing all elements receiving a score of *Partially Met* or *Not Met*. The CAP must be submitted to the MQD within 30 days of the health plan's receipt of HSAG's final 2011 External Quality Review of Compliance With Standards report. The organization should identify, for each element that requires corrective action, the interventions planned to achieve compliance with the requirement(s), the individual(s) responsible, and the timelines for completing the planned activities.

The MQD, with assistance from HSAG, will review and approve the CAP to ensure that planned interventions sufficiently address the deficiency(ies) and can be reasonably expected to bring performance into compliance with the requirements.

Appendix A. Review of the Standards and Records

Following this page are the completed compliance with standards review tools HSAG used to evaluate **Kaiser**'s performance and to document its findings, the scores it assigned associated with the findings, and when applicable, corrective actions required to bring the health plan's performance into full compliance.

Standard I—Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
1. The Health Plan oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* Contract: QUEST: 70.500 QExA: 70.500	NOTE: There are no delegated functions related to Kaiser's QUEST Program.	☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings: During the interview portion of the on-site review, HSAG confirmed that Kaiser had no delegated functions for its QUEST program. Therefore, this standard was not applicable.		
Required Actions: None		
2. Before any delegation, the Health Plan evaluates a prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* Contract: QUEST: 70.500 QExA: 70.500		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
3. There is a written agreement with each delegate. *42CFR438.230(b)(2)* Contract: QUEST: 70.500 QExA: 70.500		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
4. The written delegation agreement:		

Standard I—Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
42CFR438.230(b)(2) Contract: QUEST: 70.500 and 70.920 QExA: 70.500 and 70.920		
a. Specifies the activities and reporting responsibilities delegated to the subcontractor.		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
b. Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
c. States that the state and health plan members shall bear no liability of the health plan's failure or refusal to pay valid claims of the subcontractor.		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
d. Includes a provision that allows the health plan to: ◆ Evaluate the subcontractor's ability to perform the activities to be delegated; ◆ Monitor the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule (the frequency		☐ Met ☐ Partially Met ☐ Not Met ☒ NA

Standard I—Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
should be stated in the agreement) established by the DHS and consistent with industry standards or State laws and regulations; ◆ Identify deficiencies or areas for improvement; and ◆ Take corrective action or impose other sanctions, including but not limited to revoking delegation, if the subcontractor's performance is inadequate.		
Findings:		
Required Actions:		
e. Requires that the subcontractor follow all audit requirements outlined in the Medicaid managed care contract.		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
5. The Health Plan monitors the delegate's performance on an ongoing basis. *42CFR438.230(b)(3)* Contract: QUEST: 70.500 QExA: 70.500		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		

Standard I—Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
6. The Health Plan subjects its delegates to a formal review according to a periodic schedule established by the state, consistent with industry standards or state MCO laws and regulations. (The State's standard is annual formal reviews.) *42CFR438.230(b)(3)* Contract: QUEST: 70.500 QExA: 70.500		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		
7. If the Health Plan identifies deficiencies or areas for improvement in the subcontractor's performance, the Health Plan and the subcontractor take corrective action. *42CFR438.230(b)(4)* Contract: QUEST: 70.500 QExA: 70.500		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings:		
Required Actions:		

Standard I–Delegation Results						
Met	=	0	X	1.00	=	0
Partially Met	=	0	X	.50	=	0
Not Met	=	0	X	.00	=	0
Not Applicable	=	11		***NA***		***NA***
Total Applicable	=	0	**Total Score**		=	0
Total Score ÷ Total Applicable					=	**NA%**

Standard II—Member Information

Requirements and References	Evidence/Documentation as Submitted by the Health Plan	Score
1. The Health Plan uses easily understood language (6.9 grade level or lower) and formats for all written member materials. *42CFR438.10(b)(1)* *42CFR438.10(d)(1)(i)* Contract: QUEST: 50.320 QExA: 50.330	Policy #6547-03-02 Standards for Written Materials	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: The Standards for Written Materials policy stated that the Flesch-Kincaid scale is used to ensure that the language in member documents is easily understandable to a member who reads at a 6.9 grade reading level. Kaiser staff provided Flesch-Kincaid certificates for the member welcome letter, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) letter, and the member handbook. The on-site appeal and grievance records review indicated that the appeal resolution letters and some grievance resolution letters were not at a 6.9 grade reading level.		
Required Actions: Kaiser must ensure that written grievance and appeal resolution notices are easy to understand and at a 6.9 grade reading level or lower.		
2. The Health Plan makes all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. *42CFR438.10(d)(1)(ii)* Contract: QUEST: 50.320 QExA: 50.330	Policy #6547-03-02 Standards for Written Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Standards for Written Materials policy stated that written materials will be available in alternative formats. During the on-site interview, staff reported that materials are available in large print and that Kaiser has a process for staff to read information to members, upon request. Staff also reported that no requests for alternative formats had been made.		
Required Actions: None		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
3. The Health Plan notifies members that written information is available in alternative formats and how to access those formats. *42CFR438.10(d)(2)* Contract: QUEST: 50.320 QExA: 50.330	Language Block	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: Kaiser provided a copy of the language block stating that the information contained in the document was important and available in large print. The member handbook and the provider directory contained a different language block that offered oral interpretation services rather than written materials in alternative formats. During the on-site interview, Kaiser staff reported that the language block offering written materials in large print (and the telephone numbers to call to request them) had been inadvertently left out of the member handbook and the provider directory. Staff reported that Kaiser had compensated by inserting a language block on one printed page in the member handbook packets that were sent out and had plans to add it back into the handbook and directory at the next printing. Kaiser provided a sample member welcome packet for review on-site, which contained the one-page language block document.		
Required Actions: None		
4. All written materials are available in English, Ilocano, Tagalog, Chinese, and Korean. *42CFR438.10(c)(3)* Contract: QUEST: 50.320 QExA: 50.330	Policy #6547-01-01 Availability of QUEST Information in Alternative Formats Language Block	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Availability of QUEST Information in Alternative Formats policy stated that the materials available in the required alternate languages include the member handbook, the letter of introduction, the handout regarding EPSDT services, and the provider directory. During the on-site interview, Kaiser staff reported that these materials are already translated and can be printed locally by Kaiser. The health plan also stated that other materials are available in the alternate languages and are translated and provided upon request. Staff reported that Kaiser uses a vendor to translate and provide the additional materials.		
Required Actions: None		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
5. All written materials distributed to members includes a language block that informs the member that the document contains important information and directs the member to call the health plan to request the document in an alternative language or to have it orally translated. The language block is printed, at a minimum, in English, Ilocano, Tagalog, Chinese, and Korean. *42CFR438.10(d)(2)* Contract: QUEST: 50.320 QExA: 50.330	Language Block	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: Kaiser provided a copy of the language block stating that the information contained in the document was important and available in alternate languages. The language block appeared in English and in each of the four required alternate languages. The member handbook and the provider directory contained a different language block that offered oral interpretation services rather than written materials in alternate languages. During the on-site interview, Kaiser staff reported that the language block offering written materials in alternate languages (and the telephone numbers to call to request them) had been inadvertently left out of the member handbook and the provider directory. Staff reported that Kaiser had compensated by inserting a language block on one printed page in the member handbook packets that were sent out and had plans to add it back into the handbook and directory at the next printing. Kaiser provided a sample member welcome packet for review on-site, which contained the one-page language block document. Kaiser provided samples of the member newsletters, which did not contain the language block.		
Required Actions: Kaiser must ensure that all materials distributed to members include a language block that informs the member that the document contains important information and directs the member to call the health plan to request the document in an alternate language or to have it orally translated.		
6. The Health Plan provides oral translation services to any member who requests the service regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language. The health Plan notifies its members of the availability of	Guide to Services for Hawaii QUEST Members (member handbook) (pages 1 – 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
the oral interpretation services and informs them of how to access those services. There shall be no charge to the member for translation services. ***For QExA only***, the health plan must also provide sign language and TTD services to members with hearing impairments. *42CFR438.10(c)(4)&(5)* Contract: QUEST: 50.390 QExA: 50.395		
Findings: The member handbook and the provider directory included a language block that informed the member that interpreter services are available at no charge and offered the telephone numbers to call to request the services (including the teletype/telecommunications device for the deaf [TTY/TDD] number). The block appeared in 10 languages, including English. Kaiser provided the language interpretation reports submitted to the MQD for all four quarters of 2010. The Providing Language Assistance policy described the process for providing interpreter services. The Guidelines for Requesting an Interpreter document included step-by-step instructions for staff to arrange for interpretation services (including sign language) for doctor appointments or for admission to the hospital, and for use of the language line for telephone call interpretation. The Procedure for Providing Language Assistance Services Within the Customer Service Center policy described the process specifically for customer service staff offering interpreter services during customer service calls.		
Required Actions: None		
7. The Health Plan mails the member handbook to all newly enrolled members within 10 days of receiving the notice of member enrollment from the DHS, and annually thereafter. *42CFR438.10(f)(3)* Contract: QUEST: 50.330 QExA: 50.340	Policy #6547-01-03 Mailing of QUEST Enrollment Information	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Mailing of QUEST Enrollment Packets policy described the process for sending the enrollment packets. The policy stated that a		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
weekly verification of unused labels is done to verify that all packets due were sent. During the on-site interview, Kaiser staff clarified that the process is an internal and manual process whereby the cross-check of labels used is the tracking mechanism to determine that packets were mailed.		
Required Actions: None		
8. The Health Plan gives written notice of any significant change in program information, provided to members, at least 30 days prior to the intended effective date of the change. *42CFR438.10(f)(4)* Contract: QUEST: 50.300 QExA: 50.310	Policy #6547-03-02 Standards for Written Materials	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Standards for Written Materials policy stated that members are informed of changes in program information either via the member handbook or through letters to members. During the on-site interview, Kaiser staff reported that when mental health services were carved back into the benefit plan, Kaiser contracted with a case management agency to make outreach phone calls to affected members.		
Required Actions: None		
9. The Health Plan makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen by, the terminated provider. *42CFR438.10(f)(5)* Contract: QUEST: 40.230 QExA: 40.260	Policy #R6020-02-32A Transition of Care Member Notification and Continued Access Process Standard II.9 Approval from MQD – Kaiser Permanente received an approval form Med-QUEST to send out letters to our members, informing them of provider terminations, 30 days prior to the effective date of the termination.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: Transition of Care Member Notification policy stated that Kaiser provides notice to members 30 days in advance of the provider termination effective date. Kaiser provided an email clarification from the MQD that this notification method was acceptable. During the on-site interview, Kaiser staff clarified that Kaiser requires a six-month notice for planned, provider-initiated terminations. Staff also stated that in the past,		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
when notice was provided to members 15 days following a provider's notice, it was disruptive to members and to operations.		
Required Actions: None		
10. The Health Plan produces a provider directory for the DHS to provide assistance to members selecting a health plan. The provider directory includes information of providers organized by island including: ◆ The names, locations, and telephone numbers ◆ Non-English languages spoken by current contracted providers ◆ Board certification ◆ Identification of providers who are (or are not) accepting new patients. QUEST only: ◆ office hours, QExA only: ◆ Web-site address, if available. *42CFR438.10(f)(6)(i)* Contract: QUEST: 50.350 QExA: 50.360	Caring for You – Our Physicians and Locations	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The provider directory was organized by island and included the locations, telephone numbers, and hours of each Kaiser clinic with the names of the providers located at each clinic. The provider directory also included the providers' board certification and the non-English languages spoken by providers, as applicable. There was an icon used in the directory to indicate if providers were not accepting new patients.		
Required Actions: None		
11. The Health Plan provides member education according to the requirements of the contract. Contract:	Policy #6070-01 Patient and Family Education Guide to Services for Hawaii QUEST Members	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
QUEST: 50.310 QExA: 50.320		
Findings: The member handbook included a table of benefits and services, preventive services schedules for adults and children, information about the importance of blood pressure screenings, and class schedules for diet, exercise, and substance and tobacco use topics. The Family and Patient Education policy described, and Kaiser staff confirmed that, additional education occurs on an individualized basis with the provider using national publications. Kaiser staff reported that as an organization, Kaiser does not produce or distribute disease management materials to the membership. Member newsletters included topics such as childhood obesity, healthy aging, tips for diet and exercise, the importance of cancer screenings, and managing high blood pressure, as well as a reminder of member rights and responsibilities. Each member handbook also included class education schedules. Class topics included nutrition, exercise, pregnancy, tobacco cessation, weight management, advance directives, and a variety of classes designed to help members understand specific diagnoses.		
Required Actions: None		
12. The Health Plan's member handbook includes: *42CFR438.10* Contract: QUEST: 50.330 QExA: 50.340		
a. A table of contents.	Guide to Services for Hawaii QUEST Members (page 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook included a table of contents.		
Required Actions: None		
b. Information about roles and responsibilities of the member (QUEST only).	Guide to Services for Hawaii QUEST Members (page 40)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook described the member as a partner in his or her health care and included member responsibilities such as providing complete information, following the treatment plan, understanding benefits, and keeping appointments.		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions: None		
c. General information on managed care.	Guide to Services for Hawaii QUEST Members (page 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook described managed care as working together to provide the care the member needs when it is needed in a way that is cost effective.		
Required Actions: None		
d. QUEST: Information about the role and selection of the PCP. QExA: Information about the PCP including: ◆ The role of the PCP and the procedures to be followed to obtain needed services ◆ How to receive services prior to selecting or being assigned to a PCP ◆ That the Health Plan will provide assistance in selecting a PCP and how the member can receive this assistance. ◆ The conditions under which a member may select a specialist as his or her PCP and the process for doing so ◆ That the health plan will auto assign a member to a PCP if the member does not select a PCP within 15 days.	Guide to Services for Hawaii QUEST Members (page 7)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook stated that a primary care provider (PCP) is the doctor who is in charge of a member's care and refers the member to specialists, connecting the member to all of his or her health care.		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions: None		
e. Information about reporting changes in family status and family composition.	Guide to Services for Hawaii QUEST Members (page 42)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook described reportable changes and directed members to report these changes directly to Kaiser. The handbook provided the telephone numbers for reporting, including toll-free numbers.		
Required Actions: None		
f. Appointment procedures (and for QExA only, the minimum appointment standards).	Guide to Services for Hawaii QUEST Members (page 10)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook described situations appropriate for future and for same-day appointments, procedures for canceling appointments, and services for which members may self-refer.		
Required Actions: None		
g. Information on benefits and services including: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, ◆ Information on how to access services including EPSDT services, non-emergency transportation services, and maternity and family planning services, ◆ The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers,	Guide to Services for Hawaii QUEST Members Pages 16 – 29 Pages 10, 11, 15, 22-23 Page 8	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
◆ Information on benefits provided by the Health Plan not covered under the contract, ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract ◆ Policies on referral for specialty care and other services not provided by the member's PCP. ◆ A description of pre-certification, prior authorization, or other requirements for treatments and services. ◆ Information on how to obtain benefits when the member is out of state or off-island. ◆ An explanation of any service limitations or exclusions from coverage. *42CFR438.10(f)(6)(v through (xii)*	Page 28 Page 8, 11 Page 8, 16 Page 16 Page 17-27	
Findings: The member handbook included an extensive table of benefit descriptions and exclusions and the telephone number for scheduling. The handbook included a description of EPSDT services and how to access them, as well as each of the required topics in this requirement.		
Required Actions: None		
h. Information on cost-sharing and other fees and charges. QExA only: ◆ Including the requirement that the provider may not bill a member or assess charges or fees except: ▪ If the provider bills the member for non-covered services or for self referrals, and he or she informs the member and obtains	Page 16-27	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
prior agreement from the member regarding the cost of the procedure and the payment terms at the time of service. ◆ If a provider fails to follow plan procedures which results in nonpayment, the provider may not bill the member. *42CFR438.10(f)(6)((xi)*		
Findings: The member handbook explained that there is no charge for covered services and that the member will have to pay for noncovered services if he or she chooses to access them.		
Required Actions: None		
i. QUEST: The Health Plan's responsibility to coordinate care. QExA: Information about the role of the service coordinators, including: ◆ How to contact the service coordinator ◆ A statement that this person may be contacted as often as the member needs to ◆ The phone numbers of the service coordinators ◆ Information about yearly assessment/reassessments ◆ How and when the member will be notified of who the assigned service coordinator is ◆ The procedures for making changes to the assigned service coordinator whether initiated by the Health Plan or the member requests the	Page 5, 7	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
change. *42CFR438.10* Contract: QUEST: 50.330 QExA: 50.340		
Findings: The member handbook described the role of the customer service center and case management assistants as well as the role of the PCP in working with members to help them meet health care goals. The handbook also included a statement that Kaiser is responsible for providing and arranging care for QUEST members.		
Required Actions: None		
j. A notice stating that the Health Plan is liable only for those services authorized by the Health Plan.	Page 5, 16	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook included a statement that Kaiser will only pay for services Kaiser approved according to the member's QUEST plan benefits and that emergency services require no approval.		
Required Actions: None		
k. A statement that failure to pay for non-covered services will not result in loss of Medicaid benefits.	Page 16	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook included the statement that if a member is unable to pay for services he or she agreed to pay for, he or she will not lose QUEST eligibility.		
Required Actions: None		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
l. Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including the health plan's toll-free telephone line. QExA only: including how to access the toll-free nurse's line 24 hours a day/seven days a week.	Guide to Services for Hawaii QUEST Members	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook included a list of each Kaiser location and the telephone numbers. The handbook also included a description of utilization management and the customer service telephone number for any questions about utilization management.		
Required Actions: None		
m. Member rights as specified in 42CFR438.100 and the QUEST and QExA RFP, as stated in number 14 of this Standard. *42CFR438.10(f)(6)(iii)*	Page 38-42	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: Each of the member rights specified at 42 CFR 438.100 was included in the member handbook.		
Required Actions: None		
n. Information on advance directives for adult members including: ◆ The member's right to formulate advance directives, ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate	Page 34 - 35	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
State agency. ◆ The Health Plan's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Health Plan cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. *42CFR438.10(g)(2)* *42CFR422.128*		
Findings: The member handbook included information about the member's right to make medical decisions, including the right to have an advance directive and how to file complaints about noncompliance with advance directives. Kaiser's Advance Health Care Directives policy included Kaiser's procedures for implementation of advance directives. In addition, the member newsletter included information about classes available regarding advance directives.		
Required Actions: None		
o. The extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-	Page 12- 15	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
stabilization services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior-authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and post-stabilization services (as described in 422.113), including the use of the 911-telephone system or its local equivalent. ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)(viii) and (ix)*		
Findings: The member handbook included complete information about obtaining emergency services, including the definitions of emergency and poststabilization services. The handbook included the addresses and telephone numbers of Kaiser's emergency facilities, directed members to call 911 or go to the nearest emergency department, and informed members that if emergency services are obtained outside of the Kaiser network, Kaiser will pay according to what the member's QUEST plan covers.		
Required Actions: None		
p. Information regarding the grievance, appeal, and fair hearing procedures including: ◆ The right to file grievances and appeals with the Health Plan. ◆ The requirements and timeframes for filing grievances and appeals with the Health Plan. ◆ The availability of assistance with filing a	Page 30-33	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
grievance or an appeal with the Health Plan. ◆ The toll free numbers the member may use to file a grievance or an appeal with the Health Plan by phone. ◆ The right to a State administrative hearing. ◆ The method for obtaining a State administrative hearing. ◆ The rules that govern representation at the State administrative hearing. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State administrative hearing is filed within the timeframes specified for filing. ◆ The fact that, if benefits continue during the appeal or State administrative hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Health Plan to cover a service. QExA only: ◆ Information on the State's Ombudsman program. *42CFR438.10(f)(6)(iv)* *42CFR438.10(g)(1)*		
Findings: The member handbook included the time frames and requirements for filing grievances and appeals; however, it indicated that the		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
member had 180 days following a notice of action to file an appeal. The MQD contract allows members 30 days following a notice of action to file an appeal. The handbook did not inform members that they may have a representative, or a provider with written consent, file a grievance on their behalf. The handbook included information about how to access a State administrative hearing, but the information did not include the rules that govern representation at the hearing. The handbook included the remaining required information regarding the member grievance system.		
Required Actions: Kaiser must revise member materials to include the correct filing time frame for appeals and inform members that they may have a representative, or a provider with written consent, file a grievance on their behalf. The handbook must also include the rules that govern representation at a State administrative hearing which, at a minimum, should include that members may represent themselves at the hearing or may use legal counsel, a relative, a friend, or other spokesman.		
q. Additional information that is available upon request, including: ◆ Information on the structure and operation of the Health Plan. ◆ Physician incentive plans. *42CFR438.10(g)(3)*	Page 5, 7	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The member handbook directed members to call customer service for more information about Kaiser health plans and how the doctors are paid.		
Required Actions: None		
r. QExA only: Procedures for reporting suspected fraud.		☐ Met ☐ Partially Met ☐ Not Met ☒ NA
Findings: This requirement was not applicable to Kaiser		
Required Actions: None		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
13. The Health Plan has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: QUEST: 50.340 QExA: 50.350	Policy #R6020-02-09 Member Rights and Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Member Rights and Responsibilities policy included each of the member rights as stated at 42 CFR 438.100 and in the MQD contract, and members were informed of the rights in the member handbook. The policy also described the responsibilities of physicians and staff in respecting member rights.		
Required Actions: None		
14. The Health Plan ensures that members have the right to: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Have all records and medical and personal information remain confidential. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or	Policy #R6020-02-09 Member Rights and Responsibilities 4.1.1 4.1.3 4.1.20 4.1.11 4.1.4. and 4.1.8 5.1.9 4.1.20	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
corrected. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). ◆ Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated. ◆ Not be held liable for: ▪ The health plan's debts in the event of insolvency, ▪ The covered services provided to the member by the health plan for which the DHS does not pay the health plan, ▪ Covered services provided to the member for which the DHS or the health plan does not pay the health care provider that furnishes the services, ▪ Payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly. ◆ Only be responsible for cost sharing in accordance with 42CFR447.50 through 42 CFR447.60. QExA only: ◆ Have direct access to a women's health specialist within the network;	4.1.18 4.1.6 6.1.1 6.1.2 6.1.3 6.1.4	

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
◆ Receive a second opinion at no cost to the member; ◆ Receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than he or she would have if services were provided in-network; ◆ Receive services according to the appointment waiting time standards; ◆ Receive services in a culturally competent manner; ◆ Receive services in a coordinated manner; ◆ Have his or her privacy protected; ◆ Be included in care plan development; ◆ Have direct access to specialists (if he or she has a special healthcare need); ◆ Not have services arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition; ◆ Choose between institutional care and HCBS (if determined cost-neutral by the health plan); ◆ Receive a description of cost sharing responsibilities, if any. *42CFR438.100(b)* Contract: QUEST: 50.340 QExA: 50.350		
Findings: The Member Rights and Responsibilities policy included each member right. Member rights were included in the member handbook, the provider manual, and the Partners in Health newsletters, which as reported by Kaiser staff, are distributed to Kaiser providers, staff, and members.		
Required Actions: None		

Standard II—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
15. The Health Plan ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Health Plan treats the member. *42CFR438.100(c)* Contract: QUEST: 50.340 QExA: 50.350	Policy #R6020-02-09 Member Rights and Responsibilities (4.1.6)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Member Rights and Responsibilities policy included the provision that members may voice complaints freely without fear of discrimination or retaliation. Members were informed of this right via the member handbook. Providers were informed in the provider manual.		
Required Actions: None		
16. The Health Plan complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality. *42CFR438.100(d)* Contract: QUEST: 70.110 QExA: 70.110		☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Member Rights and Responsibilities policy included the provision that Kaiser administration is responsible for ensuring compliance with all applicable laws and regulations, including those identified in this requirement.		
Required Actions: None		

Standard II–Member Information Results						
Met	=	29	X	1.00	=	29
Partially Met	=	3	X	.50	=	1.5
Not Met	=	0	X	.00	=	0
Not Applicable	=	1		*NA*		*NA*
Total Applicable	=	32	**Total Score**		=	30.5
Total Score ÷ Total Applicable					=	95%

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
1. The Health Plan has policies and procedures and a system in place that includes an **inquiry** process, a **grievance** process, an **appeal** process, and access to the **State administrative hearing** process. *42CFR438.402(a)* Contract: QUEST: 50.805, 50.815 QExA: 50.805, 50.815	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: The Procedure for Processing Member Concern and Grievance Appeals procedure and the Resolution of Kaiser Permanente QUEST Member Grievance policy included procedures for processing grievances. The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy described procedures for processing member appeals. The policies included processes for multiple lines of business, including QUEST. During the on-site interview, Kaiser staff reported that training of appeals personnel is on a one-to-one basis because the department is small. HSAG determined, however, through the on-site interview and record review, that although Kaiser's Processing Medicaid Grievances policy described the grievance processes required by the MQD, all of the provisions of the policy were not being followed. Processes described in the policy for other lines of business that were not compliant with MQD requirements were applied to QUEST members. There were no policies that described an inquiry process. Kaiser staff reported that member inquiries typically came into the main telephone number/call center and included topics such as benefit and eligibility questions.		
Required Actions: Kaiser must develop policies and procedures that describe its inquiry process. Kaiser must also ensure that processes for QUEST member grievances are consistent with policies regarding QUEST grievances and meet the requirements as described throughout this standard and the MQD contract.		
2. The Health Plan addresses, logs, tracks and trends all expressions of dissatisfaction and maintains records of all grievances and appeals. *42CFR438.416* Contract: QUEST: 50.805 and 50.810	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
QExA: 50.805 and 50.810		
Findings: The Resolution of Kaiser Permanente QUEST Member Grievances policy described the use of the computer-based customer feedback system (CFS) based in the Lotus Notes® database for recording and documenting the substance of a grievance. The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy also described documentation of the appeal. The on-site record reviews demonstrated Kaiser's processes for maintaining documentation of grievances and appeals. Kaiser provided an example of Quality Committee Meeting minutes in which the content and processing of grievances were reviewed for trends and timeliness. The Resolution of Kaiser Permanente QUEST Member Grievances policy stated that "concerns not resolvable at point of service will be pursued with necessary investigation and follow-up actions to an appropriate and timely resolution." During the on-site interview, Kaiser staff confirmed that if an issue is resolved during the initial contact, it is not documented or processed as a grievance.		
Required Actions: Kaiser must treat all expressions of dissatisfaction as grievances, sending communication to the member, maintaining documentation, and trending those contacts. (Inquires or requests without expression of dissatisfaction do not need to be treated differently than the policy describes.) If grievances are resolved at the initial point of contact, the acknowledgment and resolution may be contained in the same letter.		
3. In handling grievances and appeals, the Health Plan must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* Contract: QUEST: 50.805 QExA: 50.805	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (4.1) Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (4.1.1)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: Kaiser's policies concerning grievances and appeals included the provision that Kaiser staff members provide assistance in filing grievances and appeals. The on-site review of grievance and appeal records found numerous incidences of staff assisting members in understanding the processes and putting grievances and appeals in writing. The member handbook described the use of LUHFY forms available in all Kaiser facilities. During the on-site interview, Kaiser staff confirmed that staff members in all Kaiser facilities are trained in routing the LUFHY forms to the appropriate staff member at each facility, who enters the information into the system. The member handbook informed members of the TTY/TDD number in several places.		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions: None		
4. The Health Plan acknowledges each grievance within five business days of the member's expression of dissatisfaction. *42CFR438.406(a)(2)* Contract: QUEST: 50.805 and 50.820 QExA: 50.805 and 50.820	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (4.1, 4th bullet)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Resolution of Kaiser Permanente QUEST Member Grievances policy stated that grievance acknowledgment letters are sent within four days. In each of the 10 grievance records reviewed on-site, the acknowledgment letters were sent the day of receipt of the grievance.		
Required Actions: None		
5. The Health Plan acknowledges each appeal within five business days of receipt of the appeal. *42CFR438.406(a)(2)* Contract: QUEST: 50.805 and 50.830 QExA: 50.805 and 50.830	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (7.3)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that each appeal is acknowledged in writing within five working days. In all ten appeal records reviewed on-site the acknowledgment letter was sent within five business days.		
Required Actions: None		
6. The Health Plan ensures that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding: ◆ An appeal of a denial that is based on a lack of	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (4.2, 4.3) Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (4.2, 4.3)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
medical necessity, ◆ A grievance regarding the denial of expedited resolution, or ◆ A grievance or appeal that involves clinical issues. *42CFR438.406(a)(3)* Contract: QUEST: 50.805 QExA: 50.805		
Findings: Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that an individual who makes a determination at any level may not decide an appeal at subsequent levels or be the subordinate of a person at a previous level of review. The Resolution of Kaiser Permanente QUEST Member Grievances policy did not contain this or a similar provision. On-site review of 10 appeal records demonstrated that in all cases the individual who made the decision on an appeal met the requirement for noninvolvement and clinical expertise. In the on-site grievance records review, there was one case in which the resolution letter was sent from the physician who was the subject of the complaint.		
Required Actions: Kaiser must include a provision in the grievance policy and develop a mechanism to ensure that individuals who make decisions on grievances are not involved in a previous level of review.		
7. The Health Plan defines grievance as an expression of dissatisfaction about any matter other than an action. *42CFR438.400(b)* Contract: QUEST: 50.820 QExA: 50820	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (Definitions)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Resolution of Kaiser Permanente QUEST Member Grievances policy included a definition of grievance that was consistent with federal Medicaid managed care regulations. The member handbook explained when a member may file a grievance.		
Required Actions: None		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
8. The Health Plan's process allows a member to file a grievance orally or in writing. *42CFR438.402(b)(3)(i)* Contract: QUEST: 50.820 QExA::50.820	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (4.1) Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (8.2, 8.3)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Resolution of Kaiser Permanente QUEST Member Grievances policy allowed for oral or written grievance filing. The on-site grievance records review demonstrated that Kaiser received grievances via telephone, e-mail, fax, or LUHFY forms completed at the Kaiser facilities.		
Required Actions: None		
9. The Health Plan's process allows a member or a member's provider or authorized representative (on behalf of the member with written consent) to file a grievance. *42CFR438.402(b)(1)* Contract: QUEST: 40.290, 50.820 QExA: 40.620, 50.820	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (2. Policy) Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (4.5)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: Although neither the Resolution of Kaiser Permanente QUEST Member Grievances policy nor the member handbook included the provision that members may have a representative or a provider, with written consent from the member, file a grievance on their behalf, it was evident via the on-site grievance records review that Kaiser accepted grievances filed by members or their representatives/providers.		
Required Actions: Kaiser must revise applicable policies and member materials to clarify that members may have a representative or a provider, with written consent, file a grievance on their behalf.		
10. The Health Plan must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires within 30 days of the initial expression of	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (4.1, 5th bullet)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
dissatisfaction. *42CFR438.408(b)&(d)* Contract: QUEST: 50.820 QExA: 50.820		
Findings: The Resolution of Kaiser Permanente QUEST Member Grievances policy included the provision that member grievances are resolved and written notice provided within 30 days of receipt of the grievance. The on-site grievance review of 10 records demonstrated that while letters were sent in a timely manner, in four cases the letter did not clearly indicate that the issues had been resolved. In one case the letter clearly indicated that the case had not been resolved and was referred to a future meeting.		
Required Actions: Kaiser must develop a process to ensure that grievances are resolved, with resolution notices provided, within 30 days of the initial expression of dissatisfaction.		
11. The Health Plan's notice of grievance resolution includes information on how to access the State grievance review process. Contract: QUEST: 50.820 QExA: 50.820	Policy #R6020-02-11 Resolution of Kaiser Permanente QUEST Member Grievances (4.1, 6th bullet)	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
Findings: Although the Resolution of Kaiser Permanente QUEST Member Grievances policy included the provision that grievance resolution letters include the member's right to request a grievance review with the State's Med-QUEST office, this was not the practice, as evidenced by the on-site records review. The policy also indicated that the member would receive a separate appeal rights letter that explained the process to request to have the decision reviewed in accordance with another policy. The additional policy described a process called a grievance-appeal, which then led to another Kaiser internal appeal process. The grievance records reviewed on-site confirmed that the resolution letter contained only information about the resolution and no State grievance review rights. The separate appeal rights letter template reviewed on-site also did not contain State grievance review rights.		
Required Actions: Kaiser must process grievances as described in the MQD contract and federal managed care regulations, including sending a resolution letter to the member that informs the member of his or her right to a State grievance review and how to access that process.		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
12. The Health Plan defines appeal as a request for review of an action. *42CFR438.400(b)* Contract: QUEST: 50.830 QExA: 50.830	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (5. Definitions)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: The Management of Post-Service Appeals policy defined an appeal as a request to reconsider a previous adverse decision made by the health plan. The Management of Pre-Service and Expedited Appeals policy did not include a definition of an appeal.		
Required Actions: While the decision to deny, limit, or reduce services is an action, there are other types of actions. Also, not all decisions are actions. Kaiser must revise its applicable documents to specify that an appeal is a request to review an action as actions are defined at 42 CFR 438.400.		
13. The Health Plan's process allows the member to file an appeal either orally or in writing, and requires the member to follow the oral request with a written request (unless the request is for expedited resolution). *42CFR438.402(b)(3)(ii)* Contract: QUEST: 50.830 QExA: 50.830	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (4.1.1)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that an appeal may be filed orally or in writing, and if an appeal is filed orally, it must be followed by a written appeal. Members were informed in the member handbook that an appeal may be filed in writing or orally to get it in on time, and that an oral appeal must be followed up in writing (unless an expedited appeal was requested).		
Required Actions: None		
14. The Health Plan's process allows a member, or a member's provider or authorized representative (on behalf of the member with the member's written consent) to file an appeal.	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (4.5)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
42CFR438.402(b)(1) Contract: QUEST: 40.290, 50.830 QExA: 40.620, 50.830		
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that an appeal may be filed by the member, a representative, or a provider with the member's written consent. Members were informed via the member handbook that they may have someone else file an appeal with written permission.		
Required Actions: None		
15. The Health Plan's process allows an appeal to be filed within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)* Contract: QUEST: 50.830 QExA: 50.830	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (4.1.1)	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy stated that appeals may be filed 180 days after the initial notice of determination. The member handbook also included the 180-day filing time frame. During the on-site interview, Kaiser staff reported that the 180-day filing time frame had been driven by NCQA standards and guidelines and provided a copy of the NCQA utilization management standards and guidelines. Kaiser staff members stated that they would be concerned if the filing time frame for members was changed to 30 days following a notice of action. Kaiser staff members described their process for allowing members additional time to file an appeal if the circumstance warranted it, and this was illustrated in the on-site record review.		
Required Actions: Kaiser must allow members 30 days to file an appeal following a notice of action and consult with the MQD regarding the practice of allowing an extended filing time frame in extenuating circumstances.		
16. The Health Plan's appeal process must provide: ◆ That oral inquiries seeking to appeal an action, are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) 8.2	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
expedited resolution. ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Health Plan must inform the member of the limited time available for this in the case of expedited resolution). ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. ◆ That included as parties to the appeal are ▪ The member and his or her representative; or ▪ The legal representative of a deceased member's estate. *42CFR438.406(b)* Contract: QUEST: 50.830 and 50.835 QExA::50.830 and 50.835	8.4 6.1.2 4.6	
Findings: Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy and the member handbook included each of the provisions in this requirement.		
Required Actions: None		
17. The Health Plan must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, within 30 calendar days from the day the Health Plan receives the appeal.	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (6.1.7)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
◆ For expedited resolution of an appeal and notice to affected parties, 3 business days from the day the Health Plan receives the appeal. *42CFR438.408(b)(2&3) &(d)(2)* Contract: QUEST: 50.830 and 50.835 QExA: 50.830 and 50.835	Policy #5054-06-A Management of Pre-Service and Expedited Appeals (Non-Medicare Members) (6.3.1)	
Findings: Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that standard appeals are resolved and notice sent to the member within 30 calendar days. The Management of Pre-Service and Expedited Appeals policy stated that the initial notice to the member must occur within 72 hours and that if the initial notice to the member is verbal, Kaiser has an additional three calendar days to notify the member in writing. The contract-required method of notification was in writing, with reasonable effort to provide oral notification in the case of expedited resolution. With the required time frame for notification in expedited cases being three business days, Kaiser's policy (72 hours plus three calendar days for initial notices provided verbally) may put written notification to the member outside the time frame of three business days. All of the appeals records reviewed on-site were standard reviews and were resolved with notice sent to the member within 30 calendar days.		
Required Actions: Kaiser must ensure that the policy is revised to clearly state the requirement that members are provided notice of expedited appeal resolutions within three business days from the date of receipt of the appeal.		
18. The notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member ▪ The right to request a State administrative hearing, and how to do so, ▪ The right to request an expedited State administrative hearing and how to do so (only when the health plan has provided an expedited appeal and the resolution was	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (8.6)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
adverse to the member), ▪ The right to request to receive benefits while the hearing is pending, and how to make the request ▪ A statement that the member may be held liable for the cost of these benefits if the hearing decision upholds the Health Plan's action. ▪ The health plan notifies the provider of the resolution but it need not be in writing. *42CFR438.408(e)* Contract: QUEST: 50.830, 50.840, and 50.845 QExA: 50.830, 50.840, and 50.845		
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that letters of appeal resolution include each of the requirements. Each of the appeal records reviewed on-site contained resolution letters that included the required content.		
Required Actions: None		
19. The Health Plan has procedures in place to notify all members in their primary language of the grievance or appeal resolution. Contract: QUEST: 50.805 QExA: 50.805	Affiliates Provider Manual – QUEST Member Grievances HPMG Provider Manual – KP QUEST Program: QUEST Member Grievances and Process for Appeals	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
Findings: There were no policies that addressed the requirement to notify members of grievance and appeal resolutions in their primary language. During the on-site interview, Kaiser staff reported that the language block sent with the member handbook offered materials in alternate languages. However, the language block indicated only that the member handbook was available in alternate languages, stating: "This information is available		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
in English, Chinese, Korean, Ilocano, and Tagalog." The language block did not indicate that other Kaiser member materials or personal communications would be available in alternate languages.		
Required Actions: Kaiser must develop a mechanism to notify members in their primary language of grievance and appeal resolutions.		
20. The Health Plan may extend the timeframes for resolution of appeals (both expedited and standard) by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Health Plan shows that there is need for additional information and how the delay is in the member's interest. *42CFR438.408(c)(1)* Contract: QUEST: 50.830 and 50.835 QExA: 50.830 and 50.835	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (8.5) Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (7.4)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision to extend the appeal decision time frame if the member requests the extension or if the health plan determines that the extension is in the interest of the member. There were no examples of an extension in the on-site appeal records review.		
Required Actions: None		
21. If the Health Plan extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)(2)* Contract: QUEST: 50.830 and 50.835 QExA::50.830 and 50.835	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (7.4) Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (8.5)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that members are notified of the reason for a delay of an extension requested by Kaiser. The member handbook included information about an extension and the provision that members would receive notice if Kaiser requests an extension.		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions: None		
22. The Health Plan must establish and maintain an expedited review process for appeals, when the Health Plan determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Health Plan's expedited review process includes: a. The Health Plan ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. b. If the Health Plan denies a request for expedited resolution of an appeal, it must ◆ Transfer the appeal to the timeframe for standard resolution, and ◆ Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two calendar days with a written notice. ◆ Inform the member that he/she may file a grievance for the denial of the expedited process. c. Notifying the MQD within 24 hours of the reason for the Health Plan's decision to extend an expedited appeal timeframe by up to 14 days. *42CFR438.410* Contract: QUEST: 50.835 QExA: 50.835	Policy #5054-06-A Management of Pre-Service and Expedited Appeals (Non-Medicare Members) (2. Policy) 7.5	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the Health Plan	Score
Findings: The provider manual informed providers that Kaiser does not take punitive or retaliatory action against a provider who requests an expedited review or supports a member's request for an appeal. The Management of Pre-Service and Expedited Appeals policy described the expedited appeal process. The policy included the provision to notify the member, verbally and in writing, if a request to expedite a review is denied. Kaiser provided a template letter that included the requirements. Kaiser, however, did not have processes for notifying the MQD of expedited requests and extensions as required in the MQD contract.		
Required Actions: Kaiser must develop a process to notify the MQD within 24 hours if an expedited appeal has been requested, granted, denied, and/ or extended by the health plan (see Section 50.835 of the MQD contract).		
23. For notice of an expedited resolution, the Health Plan must also make reasonable efforts to provide oral notice of resolution. *42CFR438.408(d)(2)(ii)* Contract: QUEST 50.835 QExA: 50.835	Policy #5054-06-A Management of Pre-Service and Expedited Appeals (Non-Medicare Members) (7.5)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
Findings: The Management of Pre-Service and Expedited Appeals policy included the provision. There were no examples of an expedited request for an appeal in the on-site appeal records review.		
Required Actions: None		
24. The Health Plan requires a member to exhaust the Health Plan's appeal process in order to request a State administrative hearing and/or an external review by the insurance commission. Contract: QUEST: 50.805 QExA: 50.805	Procedure #R6020-02-07.1 Procedure for Processing Member Concern and Grievance Appeals (7.1)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy stated that the health plan may elect to bypass the internal review and refer the case directly to an independent review organization for external review. The section in the policy that addressed provisions specific to QUEST did not address exhaustion of the internal appeal process prior to requesting		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
external reviews. During the on-site interview, Kaiser staff clarified that bypassing the internal review did not apply to QUEST members.		
Required Actions: Kaiser must clarify its policy to be consistent with the health plan's practice of having QUEST members exhaust the internal appeal process prior to requesting a State administrative hearing or an external review by the insurance commission.		
25. The Health Plan continues the member benefits if: ◆ The member requests an extension of benefits ◆ The appeal or request for State administrative hearing is filed in a timely manner—defined as on or before the later of the following: ▪ Within ten days of the Health Plan mailing the notice of adverse action, ▪ The intended effective date of the proposed adverse action. ◆ The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment, ◆ The services were ordered by an authorized provider, ◆ The original period covered by the original authorization has not expired. *42CFR438.420(b)* Contract: QUEST: 50.850 QExA: 50.850	Policy #5054-04-A Management of Post-Service Appeals (Non-Medicare) (8.6)	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
Findings: The policies stated that the appeal resolution letter would include the right to request that benefits continue and that the member may have to pay for the cost of those services if the appeal decision is adverse to the member. However, the complete provision for the continuation of benefits during the appeal or the State administrative hearing was not included in the Management of Pre-Service and Expedited Appeals policy or the Management of Post-Service Appeals policy. The provision was included in Kaiser's Grievance Appeal policy; however, that process did not		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
apply to QUEST members.		
Required Actions: Although Kaiser staff reported during the on-site interview that the termination, suspension, or reduction of previously authorized services rarely occurs, Kaiser must develop procedures to continue member benefits if the member requests an appeal and the continuation of benefits in a timely manner (as defined above) and if the required circumstances apply.		
26. If the Health Plan continues or reinstates the benefits while the appeal or State administrative hearing is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Health Plan mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day timeframe) has requested a State administrative hearing with continuation of benefits until a State administrative hearing decision is reached. ◆ A State administrative hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* Contract: QUEST: 50.850 QExA: 50.850		☐ Met ☐ Partially Met ☒ Not Met ☐ NA
Findings: Kaiser's policies did not address the period of time that benefits will be extended if they are continued during an appeal or State administrative hearing.		
Required Actions: Kaiser must develop policies that address the period of time benefits will be extended if they are continued during an appeal or State administrative hearing.		

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
27. If the final resolution of the appeal (or State administrative hearing) is adverse to the member, that is, upholds the Health Plan's action, the Health Plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section. *42CFR438.420(d)* Contract: QUEST: 50.850 QExA: 50.850		☐ Met ☐ Partially Met ☒ Not Met ☐ NA
Findings: Kaiser's policies did not address the provision for cost recovery if member benefits are continued during an appeal or State administrative hearing.		
Required Actions: Kaiser must develop policies that address cost recovery if member benefits are continued during an appeal or State administrative hearing.		
28. If the Health Plan or the State administrative hearing officer reverses a decision to deny, limit, or delay services: ◆ The Health Plan must authorize or provide the disputed services that were not furnished while the appeal was pending, promptly, and as expeditiously as the member's health condition requires. ◆ The Health Plan must pay for the disputed services the member received while the appeal was pending. *42CFR438.424* Contract:		☐ Met ☐ Partially Met ☒ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
QUEST: 50.850 QExA: 50.850		
Findings: Kaiser's policies did not address the provision of and payment for services continued during an appeal or State administrative hearing.		
Required Actions: Kaiser must develop policies that address the provision of and payment for services continued during an appeal or State administrative hearing.		
29. The Health Plan must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals and the requirements and timeframes for filing, ◆ The member's right to a State administrative hearing, how to obtain a hearing, and rules that govern representation at the State administrative hearing. ◆ The availability of assistance filing a grievance or an appeal. ◆ The member's right to have a provider or authorized representative file a grievance or appeal on his or her behalf, provided he or she has provided the written consent to do so. ◆ The toll free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State administrative hearing is filed within the timeframes specified for filing. ◆ The fact that, if benefits continue during the appeal	Affiliates Provider Manual – QUEST Member Grievances HPMG Provider Manual – QUEST Member Grievances	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
or State administrative hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Health Plan to cover a service. *42CFR438.414* Contract: QUEST: 40.290 QExA: 40.630		
Findings: Both the Affiliates Provider Manual and the HPMG Provider Manual included all of the required information regarding the member grievance system.		
Required Actions: None		

Standard III–Grievance System Results						
Met	=	13	X	1.00	=	13
Partially Met	=	10	X	.50	=	5
Not Met	=	6	X	.00	=	0
Not Applicable	=	0		*NA*		*NA*
Total Applicable	=	29	**Total Score**		=	18
Total Score ÷ Total Applicable					=	62%

Standard IV—Provider Selection

Requirements and References	Evidence/Documentation as Submitted by the Health Plan	Score
1. The Health Plan does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. ◆ Any information the member needs in order to decide among all relevant treatment options. ◆ The risks, benefits, and consequences of treatment or non-treatment. ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42CFR438.102(a)* Contract: QUEST: 40.295 QExA: 40.300	Policy #6226-02-P Credentialing & Privileging Policy and Procedure	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's written agreements with facilities and affiliated practitioners, as well as its employment agreements with physicians, included provisions that addressed the provider's right to freely communicate with members and patients about all treatment options and the option of not receiving treatment.		

Standard IV—Provider Selection		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions: None		
2. The Health Plan's policies ensure that it: ◆ does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and ◆ does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1)* *42CFR438.214(c)* Contract: QUEST: 40.295 QExA: 40.210	Policy #6226-02-P Credentialing & Privileging Policy and Procedure (III.G.3.h)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's credentialing policy and procedure included specific statements about its prohibition against discrimination based on type of license, type of patients served, and a number of other reasons, including race and gender. The policy and procedure required a signed attestation by members of the committee responsible for making decisions about provider credentialing. During the interview, staff members discussed the process for semiannual review of approvals and denials against criteria; however, staff also stated that there had been no contracting denials to date.		
Required Actions: None		

Standard IV—Provider Selection

Requirements and References	Evidence/Documentation as Submitted by the Health Plan	Score
3. If the Health Plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* Contract: QUEST: 40.210 QExA: 40.210	Policy #6226-02-P Credentialing & Privileging Policy and Procedure (III.G.6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser's credentialing policy and procedures required that a written notice of action be sent to providers based on credentialing decisions made during that process. During the interview, Kaiser staff indicated that it had not declined a contract with or the participation of a provider or group of providers, as also stated in Requirement 2 above.		
Required Actions: None		
4. The Health Plan does not employ or contract with providers excluded for participation in federal healthcare programs under either section 1128 or 1128A of the Social Security Act (must be in provider subcontracts). *42CFR438.610* Contract: QUEST: 71.900 QExA: 71.900	Policy #5054-29-B Identifying Ineligible Individuals and Entities Policy #6226-02-I-1 Policy for Identifying Sanctioned and Debarred Practitioners; Opt Out Notification	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The health plan's policies for identifying sanctioned or otherwise ineligible individuals and its credentialing procedures demonstrated that a process was in place for initial and ongoing monitoring to ensure that it does not employ or contract with providers that have been excluded from participation in federal health care programs. Kaiser had also included this requirement in its provider agreement templates. The health plan performed monthly and precontracting monitoring of federal exclusions and sanctions of providers.		
Required Actions: None		

Standard IV—Provider Selection

Requirements and References	Evidence/Documentation as Submitted by the Health Plan	Score
5. The Health Plan provides that Medicaid members are not held liable for: ◆ The Health Plan's debts in the event of the Health Plan's or subcontractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Health Plan. ◆ Covered services provided to the member for which the State or the Health Plan does not pay the health care provider that provides the services under a contractual, referral, or other arrangement. ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Health Plan provided the services directly. *42CFR438.106* Contract: QUEST: 72.130, and 50.340 QExA: 72.130 and 50.350	Guide to Services for Hawaii QUEST Members (pg. 42)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser communicated these requirements to its QUEST members in a listing of rights in the member handbook and to contracted providers via the written agreements for participation in the network (in the "Member Hold Harmless" provisions).		
Required Actions: None		

Standard IV—Provider Selection		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
6. If the Health Plan objects to providing a service on moral or religious grounds, the Health Plan must furnish information about the services it does not cover: ◆ To the DHS within 120 days of adopting the policy ◆ To member before and during enrollment ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10). *42CFR438.102(b)* Contract: QUEST: 40.280 QExA: 40.300	Kaiser Permanente has no moral or religious objection to the services defined in the RFP.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: This requirement was not applicable to Kaiser as it does not object to providing any Medicaid-covered service on moral or religious grounds.		
Required Actions: None		
7. The Health Plan has a process to ensure providers are informed and/or educated about important aspects of the Health Plan's operations, including managed care and all program requirements. Contract: QUEST: 40.290 QExA: 40.610	Provider Manuals – HPMG and Affiliates	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: In addition to its provider manual and newsletters, Kaiser had provider field representatives who ensured that external contracted		

Standard IV—Provider Selection		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
providers and their office staff had information about the health plan and its operations as necessary for their participation as a Kaiser provider. Internal provider staff participated in grand rounds, had the medical director as a resource person, and received e-mail broadcasts of important information and program or procedural changes.		
Required Actions: None		
8. The Health Plan must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Health Plan's commitment to comply with all applicable federal and State standards, ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management, ◆ Effective training and education for the compliance officer and the Health Plan's employees, ◆ Education about fraud and abuse identification and reporting in provider and member material, ◆ Effective lines of communication between the compliance officer and the Health Plan's employees, ◆ Enforcement of Standards through well	Principles of Responsibility http://kpnet.kp.org/national/compliance/program/compliance_program/fraud.html Screen shot provided	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Provider Selection		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
publicized disciplinary guidelines, ◆ Provision for internal monitoring and auditing, ◆ Provision for prompt response to detected offenses and for development of corrective action initiatives relating to the Medicaid managed care contract requirements. *42CFR438.608* Contract: QUEST: 51.100 QExA: 51.130		
Findings: Through its intranet, Kaiser makes available to its staff members and affiliated providers extensive information on the prevention and detection of FWA—including policies, principles, educational materials, and annual training modules related to its compliance program—and information about staff's responsibility for reporting potential fraud and the consequences of committing FWA. Provider agreements contained a section with requirements related to compliance with all federal, State, and Kaiser requirements. The Kaiser compliance program included separate compliance committees for the hospital, clinic system, and health plan, all reporting to a compliance operations committee, then to a regional compliance committee. The committees' charters were articulated in policy and included internal monitoring and response mechanisms. The member handbook also contained information and reporting mechanisms for members regarding FWA.		
Required Actions: None		
9. The Health Plan's fraud and abuse monitoring program shall include, at a minimum: ◆ Monitoring the billings of its providers to ensure members receive services for which the Health Plan is billed; ◆ Investigating all reports of suspected	Principles of Responsibility http://kpnet.kp.org/national/compliance/program/compliance_program/fraud.html Screen shot provided	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Provider Selection		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
fraud and over-billings; ◆ Reviewing providers for over- or under-utilization; ◆ Verifying with members the delivery of services as claimed; ◆ Reviewing and trending consumer complaints on providers. *42CFR438.608* QUEST: 51.100 QExA: 51.100		
Findings: The intranet compliance information included a description of the audit procedures that Kaiser performs to detect and prevent FWA. During the interview, Kaiser staff described the types of ongoing monitoring and reporting related to provider utilization patterns, the volume of services, referrals, and spending patterns. The health plan's compliance system was used to monitor for quality and clinical events that may trigger further review or supervision of providers and affiliates.		
Required Actions: None		

Standard IV–Provider Selection Results						
Met	=	8	X	1.00	=	8
Partially Met	=	0	X	.50	=	0
Not Met	=	0	X	.00	=	0
Not Applicable	=	1		*NA*		*NA*
Total Applicable	=	8	**Total Score**		=	8
Total Score ÷ Total Applicable					=	**100%**

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Note: These requirements are from the NCQA Standards and Guidelines for Health Plans 2010.		
1. The Health Plan has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members, including written policies and procedures for the selection and retention of providers that specify: *42CFR438.214(a)* Contract: QUEST: 40.210 QExA: 40.400 NCQA: CR1		
a. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Health Plan. (Examples include MDs, Dentists, Chiropractors, Osteopaths, Podiatrists). *42CFR438.214(a)* NCQA CR1—Element A1		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Kaiser was deemed compliant for the EQRO review of credentialing, as allowed in the MQD's quality strategy approved by CMS. Kaiser had maintained NCQA accreditation, meeting the State's policy requirements for credentialing; therefore, the credentialing review was not duplicated, per 42 CFR 438.360. HSAG received and reviewed Kaiser's NCQA accreditation report and confirmed that Kaiser had no deficiencies in this area.		
Required Actions: None		
b. The verification sources used. NCQA CR1—Element A2		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Findings:		
Required Actions:		
c. The criteria for credentialing and recredentialing. NCQA CR1—Element A3		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
d. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
e. The process for managing credentialing/ recredentialing files that meet the Health Plan's established criteria. NCQA CR1—Element A5		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
f. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		
g. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Health Plan takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
h. The process for notifying practitioners if information obtained during the Health Plan's credentialing/recredentialing process varies substantially from the information they provided to the Health Plan. NCQA CR1—Element A8		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
i. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee's decision.		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
NCQA CR1—Element A9		
Findings:		
Required Actions:		
j. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
k. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
l. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		
m. The right of practitioners to review information submitted to support their credentialing/ recredentialing application. NCQA CR1—Element B1		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
n. The right of practitioners to correct erroneous information. NCQA CR1—Element B2		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
o. The right of practitioners, upon request, to receive the status of their credentialing or recredentialing application. NCQA CR1—Element B3		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
p. The right of the applicant to receive notification of their rights under the credentialing program. NCQA CR1—Element B4		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		
q. How the Health Plan accomplishes ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions, ◆ Collecting and reviewing sanctions or limitations on licensure, ◆ Collecting and reviewing complaints, ◆ Collecting and reviewing information from identified adverse events, ◆ Implementing appropriate interventions when it identified instances of poor quality, when appropriate. NCQA CR9—Element A		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
r. The range of actions available to the Health Plan if the provider does not meet the Health Plan's standards of quality. NCQA CR10—Element A1		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
s. If the Health Plan has taken action against a practitioner for quality reasons, the Health Plan reports the action to the appropriate authorities. NCQA CR10—Element A2		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
t. A well defined appeal process for instances in which the Health Plan chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service. NCQA CR10—Element A3		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
u. How the Health Plan makes the appeal process known to practitioners. NCQA CR10—Element A4		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
2. The Health Plan designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
NCQA CR2—Element A		
Findings:		
Required Actions:		
3. The Health Plan provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds, ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
4. The Health Plan conducts timely verification (at credentialing) of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed timelines and includes: ◆ A current, valid license to practice (time limit 180 days), ◆ A valid DEA or CDS certificate (must be in effect at the time of the credentialing decision), ◆ Education and training (no time limit), including board certification (time limit 180 days), if applicable,		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
◆ Work history (time limit 365 days), ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (time limit 180 days). NCQA CR3—Elements A & B		
Findings:		
Required Actions:		
5. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation (time limit 365 days) and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation, ◆ Lack of present illegal drug use, ◆ History of loss of license and felony convictions, ◆ History of loss or limitation of privileges or disciplinary activity, ◆ Current malpractice insurance coverage, ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		
6. The Health Plan receives information on practitioner sanction before making a credentialing decision (Verification time limit—180 days), including: ◆ State sanctions, restrictions on licensure or limitations on scope of practice, ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
7. The Health Plan has a process to ensure that the offices of all practitioners meet its office-site standards. The Health Plan sets performance standards for: ◆ Office site criteria: ▪ Physical accessibility, - Handicapped access - Well-lit waiting room - Adequate seating - Posted office hours ▪ Physical appearance, ▪ Adequacy of waiting and examining room space, ▪ Availability of appointments. ▪ Medical/treatment record criteria: - Secure/confidential filing system, - Legible file markers, - Records are easily located.		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
NCQA CR6—Element A		
Findings:		
Required Actions:		
8. The Health Plan implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints, ◆ Instituting actions to improve offices that do not meet thresholds, ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds, ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining its complaint threshold was met, ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
9. The Health Plan formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information includes: ◆ A current, valid license to practice (time limit 180		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
days), ◆ A valid DEA or CDS certificate(must be in effect at the time of the credentialing decision), ◆ Board certification (time limit 180 days), if applicable, ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (time limit 180 days), ◆ State sanctions, restrictions on licensure, or limitations on scope of practice (time limit 180 days), ◆ Medicare and Medicaid sanctions (time limit 180 days). NCQA CR7—Elements A, B & D NCQA CR8—Element A		
Findings:		
Required Actions:		
10. The Health Plan has (and implements) written policies and procedures for the initial and ongoing assessment of organizational providers with which it contracts, which include:		
a. The Health Plan confirms that the organizational provider is in good standing with state and federal regulatory bodies. NCQA CR11—Element A1		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Findings:		
Required Actions:		
b. The Health Plan confirms whether the organizational provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
c. The Health Plan conducts an on-site quality assessment if the organizational provider is not accredited. NCQA CR11—Element A3		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
d. The Health Plan confirms at least every three years, that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Health Plan conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body. NCQA CR11—Element A4		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		
11. The Health Plan has a selection process and assessment criteria for each type of nonaccredited organizational provider with which it contracts. NCQA CR11—Element A		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
12. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
13. The Health Plan includes at least the following medical providers in its assessment: ◆ Hospitals, ◆ Home Health Agencies, ◆ Skilled Nursing Facilities, ◆ Free Standing Surgical Centers. NCQA CR11—Element B		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
14. The Health Plan includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings in its assessment: ◆ Inpatient ◆ Residential ◆ Ambulatory NCQA CR11—Element C		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
15. The Health Plan has documentation that organizational providers have been assessed. NCQA CR11—Element D and E		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
16. If the Health Plan delegates any NCQA-required credentialing activities, there is evidence of oversight of delegated activities. NCQA CR12		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
17. If the Health Plan delegates any NCQA-required credentialing activities, the Health Plan has a written delegation document with the delegate that: ◆ Is mutually agreed upon,		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
◆ Describes the responsibilities of the Health Plan and the delegated entity, ◆ Describes the delegated activities, ◆ Requires at least semiannual reporting by the delegated entity to the Health Plan, ◆ Describes the process by which the Health Plan evaluates the delegated entity's performance, ◆ Describes the remedies available to the Health Plan (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A		
Findings:		
Required Actions:		
18. If the delegation arrangement includes the use of PHI by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI, ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure, ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards, ◆ A stipulation that the delegate will provide members with access to their PHI, ◆ A stipulation that the delegate will inform the Health Plan if inappropriate uses of the information occur, ◆ A stipulation that the delegate will ensure that PHI		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B		
Findings:		
Required Actions:		
19. If the Health Plan delegates any NCQA-required credentialing activities, the Health Plan retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation document. NCQA CR12—Element C		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
20. For delegation agreements in effect less than 12 months, the Health Plan evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
21. For delegation agreements in effect 12 months or longer, the Health Plan audits credentialing files against NCQA standards for each year that the delegation has been in effect.		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
NCQA CR12—Element E		
Findings:		
Required Actions:		
22. For delegation agreements in effect for more than 12 months, the Health Plan performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
23. For delegation arrangements in effect 12 months or longer, the Health Plan evaluates regular reports (at least semiannually). NCQA CR12—Element G		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		
Required Actions:		
24. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the Health Plan has identified and followed up on opportunities for improvement, if applicable. NCQA CR12—Element H		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings:		

Standard V—Credentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Health Plan**	**Score**
Required Actions:		

Standard V–Credentialing Results					
Met	=	47	X 1.00	=	47
Partially Met	=	0	X .50	=	0
Not Met	=	0	X .00	=	0
Not Applicable	=	0	*NA*		*NA*
Total Applicable	=	47	**Total Score**	=	47
Total Score ÷ Total Applicable				=	100%

State of Hawaii, Department of Human Services
Med-QUEST Division (MQD)
2011 External Quality Review of Compliance With Standards
Appeals File Review Tool
for Kaiser Permanente QUEST Health Plan

Review Period:	**March 1, 2010 – February 28, 2011**
Date of Review:	**May 4 and 5, 2011**
Reviewer:	**Barb McConnell and Bonnie Marsh**
Participating Health Plan Staff Member:	**John Nelson**

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	Member ID	Date Appeal Received	Evidence of Reasonable Assistance	Date of Acknow-ledgment Letter	Acknow-ledgment Within 5 B-Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Notice Sent	Res. in Required Time Frame	Res. Notice Includes Required Content	Resolution Notice Easily Understood
Corresponding Standard			**III.3**		**III.5**	**III.6**	**III.6**				**III.17**	**III.18**	**III.19**
1	1021433	3/3/2010	M☒ N☐ U☐	3/10/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	3/10/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level. The resolution was sent in the acknowledgment letter, meeting both time frames.													
2	1119094	4/20/2010	M☒ N☐ U☐	4/23/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/19/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level.													
3	906799	4/26/2010	M☒ N☐ U☐	4/28/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/26/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level.													
4	437188	5/3/2010	M☒ N☐ U☐	5/10/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/2/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level.													
5	274176	7/7/2010	M☒ N☐ U☐	7/14/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	7/14/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level. The resolution was sent in the acknowledgment letter.													
6	484816	7/19/2010	M☒ N☐ U☐	7/26/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/18/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter not at or below a 6.9 grade reading level.													
7	867863	10/18/10	M☒ N☐ U☐	10/25/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	11/17/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level. The health plan accepted the appeal five years after the denial as the member stated that he never received the original denial correspondence.													
8	1075557	7/26/2010	M☒ N☐ U☐	7/29/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/25/10	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level.													
9	0000210246	12/13/2010	M☒ N☐ U☐	12/13/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	1/12/11	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level.													

State of Hawaii, Department of Human Services
Med-QUEST Division (MQD)
2011 External Quality Review of Compliance With Standards
Appeals File Review Tool
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1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	Member ID	Date Appeal Received	Evidence of Reasonable Assistance	Date of Acknow-ledgment Letter	Acknow-ledgment Within 5 B-Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Notice Sent	Res. in Required Time Frame	Res. Notice Includes Required Content	Resolution Notice Easily Understood
10	0001171963	1/3/2011	M☒ N☐ U☐	1/26/11	M☐ N☐ NA☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	2/2/11	M☒ N☐	M☒ N☐	M☐ N☒
Comments: The appeal resolution letter was not at or below a 6.9 grade reading level. Kaiser processed this case similar to an appeal; however, it was determined that there had not been a notice of action issued to the member at the time the member wrote a letter of explanation to the claims department. The member was notified that she was Medicaid eligible but had not yet received notice of her enrollment in Kaiser when the services were rendered. Therefore, she did not know that she should only use a Kaiser provider. Because the correspondence was received in the Maui claims department and referred to the appeals department, there was a delay in the final response. Since it was not technically an appeal and the claim was ultimately paid once the circumstances were investigated, the timeliness issue was considered NA.													
11	0000989716	2/7/2011	M☐ N☐ U☐		M☐ N☐	M☐ N☐ U☐	M☐ N☐ U☐	Y☐ N☐	Y☐ N☐		M☐ N☐	M☐ N☐	M☐ N☐
Comments:													
	# Applicable Elements		10		9	10	10				10	10	10
	# Compliant Elements		10		9	10	10				10	10	0
	Percent Compliant		100%		100%	100%	100%				100%	100%	0%

B-days=Business days
C-days=Calendar Days
Y-Yes
M=Met
N=Not Met/No
N/A=Not Applicable

Total # Applicable Elements	**69**
Total # Compliant Elements	**59**
Total Percent Compliant	**86%**

State of Hawaii, Department of Human Services
Med-QUEST Division (MQD)
2011 External Quality Review of Compliance With Standards
Grievance Record Review Tool
for Kaiser Permanente QUEST Health Plan

Review Period:	**March 1, 2010 – February 28, 2011**
Date of Review:	**May 4 and 5, 2011**
Reviewer:	**Barb McConnell and Bonnie Marsh**
Participating Health Plan Staff Member:	**Dana Miranda**

1	2	3	4	5	6	7	8	9	10	11	12
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 5 B-days	Date of Written Notice of Resolution	# of Days to Notice	Resolved and Notice Sent in 30 C-days	Decision-Maker—Previous Level	Decision-Maker—Clinical Expertise	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
Corresponding Standard				**III.4**			**III.10**	**III.6**	**III.6**	**III.11**	**III.19**
1	1042636	3/30/2010	3/30/10	M ☒ N ☐	4/7/10	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
2	346000	4/13/2010	4/13/10	M ☒ N ☐	4/23/10	10	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process. While the resolution letter was timely, it did not contain the resolution to the member's grievance issues, but rather acknowledged a future appointment that had been set with the member to discuss the complaints. The file did not contain another resolution letter or the outcome of that meeting.											
3	16192	7/24/2010	7/24/10	M ☒ N ☐	8/4/10	10	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
4	9193697	1/13/2011	1/13/11	M ☒ N ☐	2/4/11	22	M ☐ N ☒	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☐ N ☒
Comments: The resolution letter did not contain the member's right to the State grievance review process. The resolution letter was from a physician about whom the member had complained instead of being from an uninvolved party. Also, the letter did not contain the steps taken to resolve the complaints, as were listed in the notes of the grievance file. The tone of the physician's letter was not assessed as helpful or responsive.											
5	799133	2/14/2011	2/14/11	M ☒ N ☐	3/8/11	22	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☐ N ☒
Comments: The resolution letter did not contain the member's right to the State grievance review process. Also, the resolution letter stated: "we have spoken several times," and that the writer "was not able to reach you to schedule a time to talk" and to change the member's PCP.											
6	564443	6/4/2010	6/4/10	M ☒ N ☐	6/10/10	6	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process. While the resolution letter was timely, it did not contain a resolution of the member's grievance issues, only a recap of the grievance and events.											
7	7221589	9/28/2010	9/28/10	M ☒ N ☐	10/17/10	19	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
8	275511	2/28/2011	2/28/11	M ☒ N ☐	3/21/10	21	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
9	729253	2/22/2011	2/22/11	M ☒ N ☐	3/14/11	20	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐

State of Hawaii, Department of Human Services
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1	2	3	4	5	6	7	8	9	10	11	12
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 5 B-days	Date of Written Notice of Resolution	# of Days to Notice	Resolved and Notice Sent in 30 C-days	Decision-Maker—Previous Level	Decision-Maker—Clinical Expertise	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
10	224664	7/12/2010	7/12/10	M ☒ N ☐	8/3/10	22	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒	M ☒ N ☐
Comments: The resolution letter did not contain the member's right to the State grievance review process.											
# Applicable Elements				10			10	10	8	10	10
# Compliant Elements				10			6	9	8	0	8
Percent Compliant				100%			60%	90%	100%	0%	80%

B-days=Business days
C-days=Calendar Days
M=Met
N=Not Met
N/A=Not Applicable

# Applicable Elements	**58**
# Compliant Elements	**41**
Percent Compliant	**71%**

Appendix B. On-Site Review Participants

The document following this page includes the dates of HSAG's on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals participating in or observing some or all of the on-site review activities, including **Kaiser**'s key staff members who participated in the interviews and record reviews that HSAG conducted.

Review Dates

Dates for HSAG's on-site review for **Kaiser** are shown in the table below.

Table B-1—Review Dates	
Dates of On-Site Review	May 4 and 5, 2011

Participants

Participants in the 2011 external quality review of compliance with standards are listed in the following table.

Table B-2—HSAG Reviewers and Health Plan/Other Participants		
HSAG Review Team		**Title**
Team Leader	Bonnie Marsh, BSN, MA	Executive Director, State & Corporate Services
Reviewer	Barbara McConnell, OTR, MBA	Project Director, State & Corporate Services
Kaiser Participants		**Title**
Bill Clevenger, MD		Medical Director
Jessica Gouvea		Government Programs
Carol Ganiron		Government Programs Manager
Eric Nagao		Manager, Provider Relations & Contracting
Gayle Seifullin		Manager of Quality Metrics/Credentialing/Clinical Risk
Shawn Ripley		Medicare Contract Compliance Manager
Haley Hsieh		Director, Provider Contracting
John Nelson		Appeals Manager
Dana Miranda		Customer Feedback System Administrator
Other Participants		**Organization and Title**
Lily Ota		MQD
Chris Butt		MQD
Grant Shiira		MQD

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality reviews of compliance with standards for the MQD's health plans addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final report of findings.

HSAG followed identical, standardized processes for conducting the 2011 reviews for each of the five MQD contractors it reviewed (i.e., three QUEST health plans and two QExA health plans).

Objective for Conducting the Review of Compliance With Standards

The primary objective for HSAG's reviews was to provide meaningful information to the MQD and the health plans regarding the plans' compliance with requirements in five select areas. HSAG assembled a team to:

- Collaborate with the MQD to determine the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the reports of its findings.

To accomplish its objective, and based on the results of its collaborative planning with the MQD, HSAG developed and used a standardized data collection tool and processes to assess and document each organization's compliance with certain federal Medicaid managed care regulations, State rules, and the associated MQD contractual requirements. The review tool included requirements that addressed the following five performance areas:

- Standard I—Delegation
- Standard II—Member Information
- Standard III—Grievance System
- Standard IV—Provider Selection
- Standard V—Credentialing

HSAG also evaluated how each organization implemented a number of the requirements by using worksheets and tools it developed to review the organization's records and files. For each health plan, HSAG used the worksheets to review a sample of:

- Appeal records and files.
- Grievance records and files.
- Credentialing and recredentialing records and files.

The information and findings that resulted from HSAG's review will be used by the MQD and each health plan to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to Medicaid members.
- Evaluate health plan organizational strengths and identify areas for improvement.
- Identify, implement, and monitor interventions to improve the quality, accessibility, and timeliness of services.

This 2011 review was conducted in the second year of a three-year cycle of compliance reviews for MQD's contracted health plans.

Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed a standardized data-collection tool to conduct the reviews. The requirements included in the tool were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract agreement between the MQD and each health plan, as they related to the scope of the review.

HSAG also followed the guidelines set forth in the February 11, 2003, Centers for Medicare & Medicaid Services (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.*, for the following activities.

Pre-on-site Review Activities: These activities included:

- Developing the compliance review tools and associated reviewer worksheets.
- Preparing and forwarding to each health plan a customized desk review form and instructions for completing it and submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews and sending an introductory letter with a schedule of key dates to each health plan.
- Developing and forwarding to each health plan the on-site review agenda for each day of the two-day review.
- Offering and conducting technical assistance to the health plans. The assistance included previewing HSAG's desk review and on-site review processes and answering any questions the health plans had about them.

- Providing the data collection (compliance review) tool to each health plan to help facilitate its preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the MQD and documents the health plans submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each organization's operations, identify areas needing further clarification, and begin compiling interview questions before the on-site review.

On-site Review Activities: The two-day on-site reviews were conducted by two HSAG reviewers. The on-site reviews included:

- An opening session, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review/inventory of the documents HSAG requested that the health plans have available on-site.
- Interviews with the health plans' key administrative and program staff members.
- Reviews of the sample records the health plans were requested to assemble on-site.
- A closing conference during which HSAG summarized its preliminary findings from the review.

HSAG documented its findings for each health plan in the data collection (compliance review) tool and record review tools, which now serve as a comprehensive record of HSAG's findings, performance scores, and, as applicable, the actions required to bring the organization's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Table C-1 presents a chronological and a more detailed description of the above activities that HSAG performed throughout its review.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with the MQD and its contracted health plans to set the schedule and assigned HSAG reviewers to the review team for each health plan.
Step 2:	**Prepared the data-collection tool for reviewing the five standards and submitted it to the MQD for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements as set forth in the contract between the MQD and the health plans to develop the standards (groups of requirements related to broad contract areas) to be reviewed. HSAG also used the federal Medicaid managed care regulations described at 42 CFR 438, with revisions that were issued on June 14, 2002, and effective on August 13, 2002. Prior to finalizing the tool, HSAG submitted the draft to the MQD for its review, comment, and approval.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the health plans.**
	HSAG prepared and forwarded a Desk Review Form to the health plans requesting that they submit specific information and documents to HSAG within approximately 30 days of the request. The Desk Review Form included instructions for organizing and preparing the documents related to the review of the five standards and the associated file reviews; submitting documentation for HSAG's desk review; and having additional documents available as part of the on-site review.
Step 4:	**Forwarded a Documentation Request and Evaluation Form to each health plan.**
	HSAG forwarded to each health plan a Documentation Request and Evaluation Form containing the same standards and contractual requirements as the tool HSAG used to assess the organizations' compliance with each of the requirements within the standards. The Desk Review Form included instructions for completing the "Evidence/Documentation as Submitted by the Organization" portions of this form. This step (1) provided the opportunity for each health plan to identify the specific documents or other information that provided evidence of the health plan's compliance with the requirement, and (2) streamlined the ability of HSAG's reviewers to identify all applicable documentation for their review.
Step 5:	**Developed a compliance monitoring on-site review agenda and submitted it to the health plans and the MQD.**
	HSAG developed an agenda to assist each health plan's staff in planning for its participation in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review, as well as minimizing disruption to the organizations' day-to-day operations. The agenda sets the tone and expectations for the on-site review so that participants understand the process and time frames.
Step 6:	**Provided orientation and technical assistance about the compliance review process.**
	HSAG staff members provided technical assistance as requested by the health plans and the MQD in order to preview HSAG's 2011 desk- and on-site review processes and to respond to any questions from those participating.
Step 7:	**Responded to the health plans' questions related to the review and provided any other needed information before the review.**
	Prior to conducting the reviews, HSAG maintained contact with the health plans as needed to answer questions and to provide information to the key management staff members. This telephone and/or e-mail contact gave the organizations' representatives the opportunity to request clarification about the request for documentation for HSAG's desk review and on-site review processes. HSAG communicated regularly with the MQD about its discussions with the health plans and its responses to their questions.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
Step 8:	**Received the health plans' documents for HSAG's desk review and evaluated the information before conducting the on-site review.**
	HSAG reviewers used the documentation received from the health plans to gain insight into each organization's structure, provider network, services, operations, resources, quality program, and delegated functions, if applicable, and to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers: ◆ Documented findings from the review of the materials submitted by the health plans as evidence of their compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site review.
Step 9:	**Received from the health plans lists of (a) appeals, (b) grievances, and (c) credentialing/recredentialing records.**
	The Desk Review Form provided the health plans with the purpose, timelines, and instructions for submitting listings of appeals, grievances, and credentialing and recredentialing cases during the HSAG-specified period. From each of the lists, HSAG selected a sample of files that included up to 15 records for each (10 for the sample and 5 for the oversample). Approximately one week prior to each health plan's on-site review, HSAG posted the lists of files that the health plan was to have available for HSAG's review when on-site.
Step 10:	**Conducted the on-site portion of the review.**
	During the on-site review, staff members from the health plans were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: ◆ Conducted an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, the health plan's overview of its structure and processes (optional), and discussion about any changes needed to the two-day agenda and general logistical issues. ◆ Conducted interviews with the health plan's staff. Interviews were used to obtain a complete picture of the compliance with contract requirements by each health plan, to explore any issues not fully addressed in the documents that HSAG had reviewed, and to increase HSAG reviewers' overall understanding of each organization's performance. ◆ Reviewed additional documentation. HSAG reviewed additional documentation while on-site and used the standardized tool to identify relevant information sources and to document review findings. Documents reviewed on-site included written policies and procedures, minutes of key committee or other group meetings, member and provider handbooks, provider and delegate subcontracts, reports, appeal and grievance files, and credentialing/recredentialing records. ◆ Summarized findings at the completion of the on-site portion of the review. HSAG conducted a closing conference at the conclusion of the second day to

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	**HSAG…**
	provide the health plan's staff members and the MQD with a high-level summary of HSAG's preliminary findings. For each of the five standards, the findings included HSAG's assessments of the organization's strengths and, when applicable, the areas requiring corrective action.
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All five standards in the monitoring tool were reviewed for each health plan. HSAG analyzed the information to determine the health plan's performance for each of the individual elements in the standards. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which the health plans complied with the requirements. A designation of *NA* was used if an individual element did not apply to an organization during the period covered by the review. *Not scored* was used for any items that the MQD and HSAG agreed should be evaluated but not assigned a numerical score.
Step 12:	**Prepared a report of findings and required corrective actions.**
	After completing the documentation of findings and scoring for each of the five standards, HSAG prepared a draft report for each health plan that described HSAG's compliance review findings, the scores it assigned for each requirement within the standards, and HSAG's assessment of the organization's strengths and any areas requiring corrective action. The reports were forwarded to the MQD and the applicable health plan for their review and comment. Following the MQD's approval of each draft report, HSAG issued the final reports to the MQD and the applicable health plan.

Description of Data Obtained

To assess the health plans' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each organization, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Program descriptions, work plans, and annual evaluations
- Management/monitoring reports related to the areas for review
- Provider and delegate contracts
- Provider manual
- Member handbook
- Staff training materials and attendance logs
- Correspondence
- Records and files related to a sample of appeals and grievances processed by the health plan
- Records and files related to a sample of providers credentialed or recredentialed by the health plan

Additional information for the compliance review was also obtained through interaction, discussions, observations, and interviews with each health plan's key staff members.

Table C-2 lists the major data sources HSAG used in determining the compliance with requirements by each health plan, and the time period to which the data applied.

Table C-2—Description of Health Plans' Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation and interview information available to HSAG during the on-site review	March 1, 2010–February 28, 2011, and up to the dates of each organization's on-site review
Member appeal files	March 1, 2010–February 28, 2011
Member grievance files	March 1, 2010–February 28, 2011
Provider credentialing and recredentialing files	March 1, 2010–February 28, 2011

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree of performance compliance with the requirements by the health plans. A designation of *NA* was used when a requirement was not applicable to an organization during the period covered by HSAG's review. A designation of *Not Scored* was used if the MQD and HSAG agreed that a requirement should be evaluated but not assigned a rating. This scoring methodology is consistent with CMS' final 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., dated February 11, 2003. The protocol describes it 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, and
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as follows:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff members 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 follows:

- 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 provision finding of noncompliance, regardless of the findings noted for remaining components.

Data Aggregation and Analysis

From the scores it assigned for each of the requirements, HSAG calculated a total percentage of compliance score for each of the five standards and an overall percentage of compliance score across the five standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (0.00 points), and *Not Applicable* or *Not Scored* (0.00 points), and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall compliance score across the five standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing them by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, the care and services each health plan provided to members, HSAG aggregated and analyzed the data resulting from its desk- and on-site review activities. The data that HSAG aggregated and analyzed included for each health plan:

- Its documented findings describing the health plan's performance in complying with each of the requirements
- The scores it assigned to the health plan's performance for each requirement
- The total percentage of compliance score it calculated for each of the five standards
- The overall percentage of compliance score it calculated across the five standards

- Its documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*

Based on the results of the data aggregation and analysis, HSAG prepared a draft report of its external quality review of compliance findings for each health plan. The reports described each organization's strengths and, when applicable, corrective actions required to bring its performance into compliance with the requirements. The reports also included, as an attachment, the compliance review tools HSAG used to evaluate the organizations' performance and to document its findings, and the performance scores it assigned for each requirement. HSAG forwarded the draft reports to the MQD and to the applicable organizations for their review and comment prior to issuing the final reports.

Appendix D. Corrective Action Plan

Following this page is a document HSAG prepared for **Kaiser** to use in preparing its corrective action plan. The template includes each of the requirements for which HSAG assigned a performance score of *Partially Met* or *Not Met*, and for each of the requirements, HSAG's findings and the actions required to bring the organization's performance into full compliance with the requirement.

Instructions for completing and submitting the CAP are included on the first page of the CAP document that follows.

Criteria that will be used in evaluating the sufficiency of the CAP are:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take
- The degree to which the planned activities/interventions meet the intent of the requirement
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement
- The appropriateness of the timeline for correcting the deficiency

Corrective action plans that do not meet the above criteria will require resubmission of the CAP by the organization until it is approved by the MQD and HSAG. Implementation of the CAP may begin once approval is received.

State of Hawaii
Med-QUEST Division
Kaiser Permanente QUEST Health Plan
Corrective Action Plan

Instructions: For each of the requirements listed below that HSAG scored as either *Partially Met* or *Not Met*, identify the following:

- Interventions planned by your organization to achieve compliance with the requirements
- Individual(s) responsible for ensuring that the planned interventions are completed
- Proposed timeline for completing each planned intervention

This plan is due to the MQD and HSAG no later than 30 days following receipt of the final 2011 External Quality Review of Compliance With Standards report. The CAP should be posted to both the MQD's FTP site (label the document Kaiser /CAP/Date Submitted) and to the HSAG FTP site in the plan-specific folder "2011 Compliance Review/Corrective Action Plan." The MQD, with assistance from HSAG, will review and approve the CAP to ensure that it sufficiently addresses the interventions needed to bring performance into compliance with the requirements. Approval of the CAP will be communicated in writing, and, once approved, CAP activities and interventions may begin. Follow-up monitoring will occur to ensure that all planned activities and interventions were completed.

Standard II—Member Information

1. The Health Plan uses easily understood language (6.9 grade level or lower) and formats for all written member materials.

42CFR438.10(b)(1)
42CFR438.10(d)(1)(i)

Contract:
QUEST: 50.320
QExA: 50.330

HSAG Findings:

The Standards for Written Materials policy stated that the Flesch-Kincaid scale is used to ensure that the language in member documents is easily understandable to a member who reads at a 6.9 grade reading level. Kaiser staff provided Flesch-Kincaid certificates for the member welcome letter, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) letter, and the member handbook. The on-site appeal and grievance records review indicated that the appeal resolution letters and some grievance resolution letters were not at a 6.9 grade reading level.

Required Action(s):

Kaiser must ensure that written grievance and appeal resolution notices are easy to understand and at a 6.9 grade reading level or lower.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard II—Member Information

5. All written materials distributed to members includes a language block that informs the member that the document contains important information and directs the member to call the health plan to request the document in an alternative language or to have it orally translated. The language block is printed, at a minimum, in English, Ilocano, Tagalog, Chinese, and Korean.

42CFR438.10(d)(2)

Contract:
QUEST: 50.320
QExA: 50.330

HSAG Findings:

Kaiser provided a copy of the language block stating that the information contained in the document was important and available in alternate languages. The language block appeared in English and in each of the four required alternate languages. The member handbook and the provider directory contained a different language block that offered oral interpretation services rather than written materials in alternate languages. During the on-site interview, Kaiser staff reported that the language block offering written materials in alternate languages (and the telephone numbers to call to request them) had been inadvertently left out of the member handbook and the provider directory. Staff reported that Kaiser had compensated by inserting a language block on one printed page in the member handbook packets that were sent out and had plans to add it back into the handbook and directory at the next printing. Kaiser provided a sample member welcome packet for review on-site, which contained the one-page language block document. Kaiser provided samples of the member newsletters, which did not contain the language block.

Required Action(s):

Kaiser must ensure that all materials distributed to members include a language block that informs the member that the document contains important information and directs the member to call the health plan to request the document in an alternate language or to have it orally translated.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard II—Member Information

12. The Health Plan's member handbook includes:

42CFR438.10

Contract:
QUEST: 50.330
QExA: 50.340

p. Information regarding the grievance, appeal, and fair hearing procedures including:

- The right to file grievances and appeals with the Health Plan.
- The requirements and timeframes for filing grievances and appeals with the Health Plan.
- The availability of assistance with filing a grievance or an appeal with the Health Plan.
- The toll free numbers the member may use to file a grievance or an appeal with the Health Plan by phone.
- The right to a State administrative hearing.
- The method for obtaining a State administrative hearing.
- The rules that govern representation at the State administrative hearing.
- The fact that, when requested by the member, benefits will continue if the appeal or request for State administrative hearing is filed within the timeframes specified for filing.
- The fact that, if benefits continue during the appeal or State administrative hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member.
- Appeal rights available to providers to challenge the failure of the Health Plan to cover a service.

QExA only:

- Information on the State's Ombudsman program.

42CFR438.10(f)(6)(iv)

42CFR438.10(g)(1)

HSAG Findings:

The member handbook included the time frames and requirements for filing grievances and appeals; however, it indicated that the member had 180 days following a notice of action to file an appeal. The MQD contract allows members 30 days following a notice of action to file an appeal. The handbook did not inform members that they may have a representative, or a provider with written consent, file a grievance on their behalf. The handbook included information about how to access a State administrative hearing, but the information did not include the rules that govern representation at the hearing. The handbook included the remaining required information regarding the member grievance system.

Required Action(s):

Kaiser must revise member materials to include the correct filing time frame for appeals and inform members that they may have a representative, or a provider with written consent, file a grievance on their behalf. The handbook must also include the rules that govern representation at a State administrative hearing which, at a minimum, should include that members may represent themselves at the hearing or may use legal counsel, a relative,

Standard II—Member Information		
a friend, or other spokesman.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Grievance System

1. The Health Plan has policies and procedures and a system in place that includes an **inquiry** process, a **grievance** process, an **appeal** process, and access to the **State administrative hearing** process.

42CFR438.402(a)

Contract:
QUEST: 50.805, 50.815
QExA: 50.805, 50.815

HSAG Findings:

The Procedure for Processing Member Concern and Grievance Appeals procedure and the Resolution of Kaiser Permanente QUEST Member Grievance policy included procedures for processing grievances. The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy described procedures for processing member appeals. The policies included processes for multiple lines of business, including QUEST. During the on-site interview, Kaiser staff reported that training of appeals personnel is on a one-to-one basis because the department is small. HSAG determined, however, through the on-site interview and record review, that although Kaiser's Processing Medicaid Grievances policy described the grievance processes required by the MQD, all of the provisions of the policy were not being followed. Processes described in the policy for other lines of business that were not compliant with MQD requirements were applied to QUEST members. There were no policies that described an inquiry process. Kaiser staff reported that member inquiries typically came into the main telephone number/call center and included topics such as benefit and eligibility questions.

Required Action(s):

Kaiser must develop policies and procedures that describe its inquiry process. Kaiser must also ensure that processes for QUEST member grievances are consistent with policies regarding QUEST grievances and meet the requirements as described throughout this standard and the MQD contract.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

2. The Health Plan addresses, logs, tracks and trends all expressions of dissatisfaction and maintains records of all grievances and appeals.

42CFR438.416

Contract:
QUEST: 50.805 and 50.810
QExA: 50.805 and 50.810

HSAG Findings:

The Resolution of Kaiser Permanente QUEST Member Grievances policy described the use of the computer-based customer feedback system (CFS) based in the Lotus Notes® database for recording and documenting the substance of a grievance. The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy also described documentation of the appeal. The on-site record reviews demonstrated Kaiser's processes for maintaining documentation of grievances and appeals. Kaiser provided an example of Quality Committee Meeting minutes in which the content and processing of grievances were reviewed for trends and timeliness. The Resolution of Kaiser Permanente QUEST Member Grievances policy stated that "concerns not resolvable at point of service will be pursued with necessary investigation and follow-up actions to an appropriate and timely resolution." During the on-site interview, Kaiser staff confirmed that if an issue is resolved during the initial contact, it is not documented or processed as a grievance.

Required Action(s):

Kaiser must treat all expressions of dissatisfaction as grievances, sending communication to the member, maintaining documentation, and trending those contacts. (Inquires or requests without expression of dissatisfaction do not need to be treated differently than the policy describes.) If grievances are resolved at the initial point of contact, the acknowledgment and resolution may be contained in the same letter.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

6. The Health Plan ensures that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding:
   - An appeal of a denial that is based on a lack of medical necessity,
   - A grievance regarding the denial of expedited resolution, or
   - A grievance or appeal that involves clinical issues.

42CFR438.406(a)(3)

Contract:
QUEST: 50.805
QExA: 50.805

HSAG Findings:

Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that an individual who makes a determination at any level may not decide an appeal at subsequent levels or be the subordinate of a person at a previous level of review. The Resolution of Kaiser Permanente QUEST Member Grievances policy did not contain this or a similar provision. On-site review of 10 appeal records demonstrated that in all cases the individual who made the decision on an appeal met the requirement for noninvolvement and clinical expertise. In the on-site grievance records review, there was one case in which the resolution letter was sent from the physician who was the subject of the complaint.

Required Action(s):

Kaiser must include a provision in the grievance policy and develop a mechanism to ensure that individuals who make decisions on grievances are not involved in a previous level of review.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

9. The Health Plan's process allows a member or a member's provider or authorized representative (on behalf of the member with written consent) to file a grievance.

42CFR438.402(b)(1)

Contract:
QUEST: 40.290, 50.820
QExA: 40.620, 50.820

HSAG Findings:

Although neither the Resolution of Kaiser Permanente QUEST Member Grievances policy nor the member handbook included the provision that members may have a representative or a provider, with written consent from the member, file a grievance on their behalf, it was evident via the on-site grievance records review that Kaiser accepted grievances filed by members or their representatives/providers.

Required Action(s):

Kaiser must revise applicable policies and member materials to clarify that members may have a representative or a provider, with written consent, file a grievance on their behalf.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

10. The Health Plan must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires within 30 days of the initial expression of dissatisfaction.

42CFR438.408(b)&(d)

Contract:
QUEST: 50.820
QExA: 50.820

HSAG Findings:

The Resolution of Kaiser Permanente QUEST Member Grievances policy included the provision that member grievances are resolved and written notice provided within 30 days of receipt of the grievance. The on-site grievance review of 10 records demonstrated that while letters were sent in a timely manner, in four cases the letter did not clearly indicate that the issues had been resolved. In one case the letter clearly indicated that the case had not been resolved and was referred to a future meeting.

Required Action(s):

Kaiser must develop a process to ensure that grievances are resolved, with resolution notices provided, within 30 days of the initial expression of dissatisfaction.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System		
11. The Health Plan's notice of grievance resolution includes information on how to access the State grievance review process. Contract: QUEST: 50.820 QExA: 50.820		
HSAG Findings: Although the Resolution of Kaiser Permanente QUEST Member Grievances policy included the provision that grievance resolution letters include the member's right to request a grievance review with the State's Med-QUEST office, this was not the practice, as evidenced by the on-site records review. The policy also indicated that the member would receive a separate appeal rights letter that explained the process to request to have the decision reviewed in accordance with another policy. The additional policy described a process called a grievance-appeal, which then led to another Kaiser internal appeal process. The grievance records reviewed on-site confirmed that the resolution letter contained only information about the resolution and no State grievance review rights. The separate appeal rights letter template reviewed on-site also did not contain State grievance review rights.		
Required Action(s): Kaiser must process grievances as described in the MQD contract and federal managed care regulations, including sending a resolution letter to the member that informs the member of his or her right to a State grievance review and how to access that process.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Grievance System		
12. The Health Plan defines appeal as a request for review of an action. *42CFR438.400(b)* Contract: QUEST: 50.830 QExA: 50.830		
HSAG Findings: The Management of Post-Service Appeals policy defined an appeal as a request to reconsider a previous adverse decision made by the health plan. The Management of Pre-Service and Expedited Appeals policy did not include a definition of an appeal.		
Required Action(s): While the decision to deny, limit, or reduce services is an action, there are other types of actions. Also, not all decisions are actions. Kaiser must revise its applicable documents to specify that an appeal is a request to review an action as actions are defined at 42 CFR 438.400.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Grievance System

15. The Health Plan's process allows an appeal to be filed within 30 calendar days from the date of the notice of action.

42CFR438.402(b)(2)

Contract:
QUEST: 50.830
QExA: 50.830

HSAG Findings:

The Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy stated that appeals may be filed 180 days after the initial notice of determination. The member handbook also included the 180-day filing time frame. During the on-site interview, Kaiser staff reported that the 180-day filing time frame had been driven by NCQA standards and guidelines and provided a copy of the NCQA utilization management standards and guidelines. Kaiser staff members stated that they would be concerned if the filing time frame for members was changed to 30 days following a notice of action. Kaiser staff members described their process for allowing members additional time to file an appeal if the circumstance warranted it, and this was illustrated in the on-site record review.

Required Action(s):

Kaiser must allow members 30 days to file an appeal following a notice of action and consult with the MQD regarding the practice of allowing an extended filing time frame in extenuating circumstances.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

17. The Health Plan must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires:
    - For standard resolution of appeals, within 30 calendar days from the day the Health Plan receives the appeal.
    - For expedited resolution of an appeal and notice to affected parties, 3 business days from the day the Health Plan receives the appeal.

42CFR438.408(b)(2&3) &(d)(2)

Contract:
QUEST: 50.830 and 50.835
QExA: 50.830 and 50.835

HSAG Findings:

Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy included the provision that standard appeals are resolved and notice sent to the member within 30 calendar days. The Management of Pre-Service and Expedited Appeals policy stated that the initial notice to the member must occur within 72 hours and that if the initial notice to the member is verbal, Kaiser has an additional three calendar days to notify the member in writing. The contract-required method of notification was in writing, with reasonable effort to provide oral notification in the case of expedited resolution. With the required time frame for notification in expedited cases being three business days, Kaiser's policy (72 hours plus three calendar days for initial notices provided verbally) may put written notification to the member outside the time frame of three business days. All of the appeals records reviewed on-site were standard reviews and were resolved with notice sent to the member within 30 calendar days.

Required Action(s):

Kaiser must ensure that the policy is revised to clearly state the requirement that members are provided notice of expedited appeal resolutions within three business days from the date of receipt of the appeal.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System		
19. The Health Plan has procedures in place to notify all members in their primary language of the grievance or appeal resolution. Contract: QUEST: 50.805 QExA: 50.805		
HSAG Findings: There were no policies that addressed the requirement to notify members of grievance and appeal resolutions in their primary language. During the on-site interview, Kaiser staff reported that the language block sent with the member handbook offered materials in alternate languages. However, the language block indicated only that the member handbook was available in alternate languages, stating: "This information is available in English, Chinese, Korean, Ilocano, and Tagalog." The language block did not indicate that other Kaiser member materials or personal communications would be available in alternate languages.		
Required Action(s): Kaiser must develop a mechanism to notify members in their primary language of grievance and appeal resolutions.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Grievance System

22. The Health Plan must establish and maintain an expedited review process for appeals, when the Health Plan determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Health Plan's expedited review process includes:
    a. The Health Plan ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.
    b. If the Health Plan denies a request for expedited resolution of an appeal, it must
        - Transfer the appeal to the timeframe for standard resolution, and
        - Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two calendar days with a written notice.
        - Inform the member that he/she may file a grievance for the denial of the expedited process.
    c. Notifying the MQD within 24 hours of the reason for the Health Plan's decision to extend an expedited appeal timeframe by up to 14 days.

42CFR438.410

Contract:
QUEST: 50.835
QExA: 50.835

HSAG Findings:

The provider manual informed providers that Kaiser does not take punitive or retaliatory action against a provider who requests an expedited review or supports a member's request for an appeal. The Management of Pre-Service and Expedited Appeals policy described the expedited appeal process. The policy included the provision to notify the member, verbally and in writing, if a request to expedite a review is denied. Kaiser provided a template letter that included the requirements. Kaiser, however, did not have processes for notifying the MQD of expedited requests and extensions as required in the MQD contract.

Required Action(s):

Kaiser must develop a process to notify the MQD within 24 hours if an expedited appeal has been requested, granted, denied, and/ or extended by the health plan (see Section 50.835 of the MQD contract).

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

24. The Health Plan requires a member to exhaust the Health Plan's appeal process in order to request a State administrative hearing and/or an external review by the insurance commission.

Contract:
QUEST: 50.805
QExA: 50.805

HSAG Findings:

Both the Management of Pre-Service and Expedited Appeals policy and the Management of Post-Service Appeals policy stated that the health plan may elect to bypass the internal review and refer the case directly to an independent review organization for external review. The section in the policy that addressed provisions specific to QUEST did not address exhaustion of the internal appeal process prior to requesting external reviews. During the on-site interview, Kaiser staff clarified that bypassing the internal review did not apply to QUEST members.

Required Action(s):

Kaiser must clarify its policy to be consistent with the health plan's practice of having QUEST members exhaust the internal appeal process prior to requesting a State administrative hearing or an external review by the insurance commission.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System

25. The Health Plan continues the member benefits if:
    - The member requests an extension of benefits
    - The appeal or request for State administrative hearing is filed in a timely manner—defined as on or before the later of the following:
        - Within ten days of the Health Plan mailing the notice of adverse action,
        - The intended effective date of the proposed adverse action.
    - The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized course of treatment,
    - The services were ordered by an authorized provider,
    - The original period covered by the original authorization has not expired.

42CFR438.420(b)

Contract:
QUEST: 50.850
QExA: 50.850

HSAG Findings:

The policies stated that the appeal resolution letter would include the right to request that benefits continue and that the member may have to pay for the cost of those services if the appeal decision is adverse to the member. However, the complete provision for the continuation of benefits during the appeal or the State administrative hearing was not included in the Management of Pre-Service and Expedited Appeals policy or the Management of Post-Service Appeals policy. The provision was included in Kaiser's Grievance Appeal policy; however, that process did not apply to QUEST members.

Required Action(s):

Although Kaiser staff reported during the on-site interview that the termination, suspension, or reduction of previously authorized services rarely occurs, Kaiser must develop procedures to continue member benefits if the member requests an appeal and the continuation of benefits in a timely manner (as defined above) and if the required circumstances apply.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System
26. If the Health Plan continues or reinstates the benefits while the appeal or State administrative hearing is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Health Plan mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day timeframe) has requested a State administrative hearing with continuation of benefits until a State administrative hearing decision is reached. ◆ A State administrative hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* Contract: QUEST: 50.850 QExA: 50.850
HSAG Findings: Kaiser's policies did not address the period of time that benefits will be extended if they are continued during an appeal or State administrative hearing.
Required Action(s): Kaiser must develop policies that address the period of time benefits will be extended if they are continued during an appeal or State administrative hearing.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard III—Grievance System		
27. If the final resolution of the appeal (or State administrative hearing) is adverse to the member, that is, upholds the Health Plan's action, the Health Plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section. *42CFR438.420(d)* Contract: QUEST: 50.850 QExA: 50.850		
HSAG Findings: Kaiser's policies did not address the provision for cost recovery if member benefits are continued during an appeal or State administrative hearing.		
Required Action(s): Kaiser must develop policies that address cost recovery if member benefits are continued during an appeal or State administrative hearing.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Standard III—Grievance System		
28. If the Health Plan or the State administrative hearing officer reverses a decision to deny, limit, or delay services: ◆ The Health Plan must authorize or provide the disputed services that were not furnished while the appeal was pending, promptly, and as expeditiously as the member's health condition requires. ◆ The Health Plan must pay for the disputed services the member received while the appeal was pending. *42CFR438.424* Contract: QUEST: 50.850 QExA: 50.850		
HSAG Findings: Kaiser's policies did not address the provision of and payment for services continued during an appeal or State administrative hearing.		
Required Action(s): Kaiser must develop policies that address the provision of and payment for services continued during an appeal or State administrative hearing.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

HEDIS® 2010
COMPLIANCE AUDIT™
FINAL REPORT OF FINDINGS
for
KAISER PERMANENTE QUEST

July 2010

HSAG HEALTH SERVICES ADVISORY GROUP

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Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

for **Kaiser Permanente QUEST**

Summary Report

This section includes basic audit information, including the audit organization information, audit validation signatures, name of the managed care organization (MCO) undergoing the audit, audit team composition, and a summary of pre-on-site activities.

Information Systems Capabilities Assessment

This section includes a summary of the auditor's assessment findings of the MCO's information systems (IS) capabilities and any impact on Healthcare Effectiveness Data and Information Set (HEDIS®) reporting.[1-1] This includes facts on claims, membership and provider data, medical record review processes, supplemental data, data integration, data control, and measure calculation processes.

Summary of Key Audit Findings/Compliance With IS Standards

This section presents the MCO's compliance with each IS standard, along with the impact on HEDIS reporting of each issue related to the standard.

Medical Record Review Validation Findings

In this section, a description of the auditor's methodology for medical record review validation is presented and the results of the final medical record review validation are displayed.

Audit Results

This section discusses the two audit results that can be assigned to a measure and the rationale for their selection. The completed Interactive Data Submission System (IDSS) can be found in Appendix C.

Final Audit Statement

This section includes the fully executed Final Audit Statement.

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

About the NCQA-Licensed Audit Organization

Health Services Advisory Group, Inc. (HSAG) is an organization licensed by the National Committee for Quality Assurance (NCQA) to perform HEDIS Compliance Audits.[2-1] HSAG currently employs eight certified HEDIS compliance auditors.

NCQA-Licensed Organization
Health Services Advisory Group, Inc.
1600 East Northern Avenue, Suite 100
Phoenix, AZ 85020

Audit Director
Margaret Ketterer, RN, BSN, CHCA
Executive Director, Audits/State and Corporate Services

Lead Auditor
David Mabb, MS, CHCA
Certified HEDIS Compliance Auditor

Audit Validation Signatures

HSAG conducted an independent audit of measurement year (MY) 2009 HEDIS data from **Kaiser Permanente QUEST** (**Kaiser QUEST**) consistent with the 2010 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5. The audit incorporated two main components:

- A detailed assessment of the MCO's IS capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including computer programming and query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed for 2010 HEDIS data production and reporting. The audit extends to include any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

[2-1] NCQA HEDIS® Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

HSAG used a number of different methods and information sources to conduct the audit, including:

1. Teleconference calls with **Kaiser QUEST** personnel and vendor representatives, as necessary.

2. Detailed review of **Kaiser QUEST's** completed responses to the HEDIS Record of Administration, Data Management and Processes (HEDIS Roadmap) published by NCQA as *Appendix 2 to HEDIS Volume 5*, and updated information communicated by NCQA to the audit team directly.

3. On-site meetings in **Kaiser QUEST's** offices, including:
   a. Staff interviews.
   b. Live system and procedure documentation.
   c. Documentation review and requests for additional information.
   d. Primary HEDIS data source verification.
   e. Programming logic review and inspection of dated job logs.
   f. Computer database and file structure review.
   g. Discussion and feedback sessions.

4. Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.

5. If the hybrid method was used, reabstraction of a sample of medical records selected by the auditors, with a comparison of the results to **Kaiser QUEST's** review determinations for the same records.

6. Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.

7. Accuracy checks of the final HEDIS rates as presented within the data submission worksheet completed by the MCO.

8. Interviews of a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, IS director, quality management director, enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that provided or processed HEDIS 2010 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

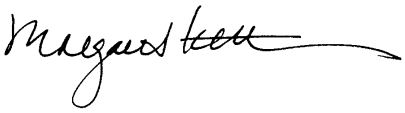
The preparation and provision of the 2010 Final Audit Report is the responsibility of **Kaiser QUEST** management. Based on the auditor's examination, it is the auditor's responsibility to express an opinion on the 2010 Final Audit Report using procedures NCQA and HSAG considered necessary to obtain a reasonable basis for rendering an opinion. The auditor's examination, in accordance with the 2010 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5, included procedures to obtain reasonable assurance that the accompanying 2010 Final Audit Report presents fairly, in all material respects, **Kaiser QUEST's** performance with respect to the *HEDIS 2010 Technical Specifications*.

The report that follows represents our findings as verified by the following signatures:

July 15, 2010

David Mabb, MS, CHCA Date

Lead Auditor



July 15, 2010

Margaret Ketterer, RN, BSN, CHCA Date

HSAG Audit Director

MCO and Audit Information

HSAG conducted the type of audit described below. Basic information about the MCO also appears in the table, including the office location(s) involved in the 2010 HEDIS Compliance Audit.

Audit Scope:	**Medicaid HEDIS Reporting**
MCO:	**Kaiser Permanente QUEST**
MCO Location(s):	**711 Kapiolani Boulevard Honolulu, HI 96808**
Contact:	**Ms. Jill McCready, MSPH**
Title:	**Sr. Planning Analyst, HEDIS Lead**
Telephone:	**(808) 432-5223**
E-Mail:	**jill.a.mccready@kp.org**
NCQA Org Id:	**124**
NCQA Submission ID(s):	**4019**
Certified Software Vendor:	**(H)**
Certified Survey Vendor:	**HSAG**

Audit Team Composition

The HSAG audit team is composed of both NCQA-Certified and non-certified individuals. The team is assembled based on the full complement of skills required for the audit and requirements of the particular MCO. Some team members, including the lead auditor, participate in the on-site meetings at the MCO office; others conduct their work at HSAG offices.

Kaiser QUEST's audit team is composed of the following members in the designated positions. Each individual's particular expertise is described in Table 2-1.

Table 2-1—Audit Team

Audit Team Member	Certified Auditor (Yes/No)	On-site (Yes/No)	Dates of Involvement	Position	Skills/Expertise
Margaret Ketterer	Yes	No	January 2010 - June 2010	Executive Director, Audits/State & Corporate Services	Management of Audit Department, certified HEDIS auditor, HEDIS knowledge, interviewing skills, medical record review advisor, and clinical consultant
David Mabb	Yes	Yes	January 2010 - June 2010	Lead Auditor, Source Code Review Manager & Associate Director, Audits/State & Corporate Services	Certified HEDIS auditor, HEDIS knowledge, source code review management, statistics, analysis, and source code programming knowledge
Marilea Rose	No	No	January 2010 - June 2010	Medical Record Review Over-read Process Supervisor	Medical record review, clinical consulting and expertise, abstraction, tool development, and supervision of nurse reviewers
Ron Holcomb	No	No	January 2010 - June 2010	Source Code Reviewer	Statistics, analysis, and source code programming knowledge
Dan Moore	No	No	January 2010 - June 2010	Source Code Reviewer	Statistics, analysis, and source code programming knowledge
Alan Dickson	No	No	January 2010 - June 2010	Source Code Reviewer	Statistics, analysis, and source code programming knowledge

Table 2-1—Audit Team					
Warren Harris	No	No	January 2010 - June 2010	Source Code Reviewer	Statistics, analysis, and source code programming knowledge
Tammy GianFrancisco	No	No	January 2010 - June 2010	Administrative Assistant III	Health plan and physician organization communications, project coordination, HEDIS and P4P knowledge, scheduling, organization, tracking, & administrative support

Overview of Pre-On-Site Activity

HSAG conducted the following activities prior to meeting with MCO representatives on-site, including:

1. E-mail and telephone correspondence with **Kaiser QUEST** explaining the scope and methods of the audit and time frames for major audit activities.
2. Detailed review of **Kaiser QUEST's** completed responses to the Roadmap published by NCQA as Appendix 2 to HEDIS Volume 5. The review included a methodical inventory of **Kaiser QUEST's** submission, including verification that all questions were addressed and all necessary documents were supplied. If any requested information was missing or otherwise not clear, HSAG notified **Kaiser QUEST** and obtained supplemental responses.
3. Compilation of a standardized set of comprehensive working papers for the audit, including all auditor and plan correspondence, required documentation, work product, special analyses and findings, results of medical record reabstraction and source code review, corrective actions (if applicable), and audit reports. The working papers follow a consistent format used by HSAG, as required by NCQA.
4. Determination of the number and locations of the on-site meetings, demonstrations, and interviews with personnel critical to HEDIS data production and reporting. Based on a review of the Roadmap responses and discussions with **Kaiser QUEST**, the audit team decided to hold on-site meetings where the main production system is located and HEDIS reports are produced.
5. Preparation of an on-site agenda, which was sent to **Kaiser QUEST** to initiate meeting scheduling and cover the scope and contents of on-site activities. The duration of the site visit was two days and the agenda included MCO presentations, auditor-to-staff interviews, system demonstrations and data processing observations, computer programming review (if not already completed), primary source verification of data samples, and feedback sessions.
6. Forwarding of the on-site agenda to the MCO approximately one week prior to the site visit. The agenda outlined the goals, processes, timing, and attendee list for the on-site meetings.
7. Review of source code or the certified software report, computer programming, and query language used by **Kaiser QUEST** to calculate HEDIS measures. The review included a detailed, line-by-line evaluation of the computerized logic used:
   a. To identify the population eligible for HEDIS denominators (e.g., based on member age, gender, and clinical conditions).
   b. To determine if members were continuously enrolled for the required period.
   c. To determine event-based HEDIS numerators (e.g., identifying procedure codes and comparing the codes to dates of services).
   d. To calculate HEDIS statistics (e.g., ratios or rates per 1,000 observations).
8. Validation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) sample frame. The validation included a review of specific reporting methods used for HEDIS/CAHPS measures, including:

a. A detailed evaluation of the computer programming (source code) used to access and manipulate data. If the sample frame was generated using NCQA-certified software, the validation team ensured that the sample frame method had received a *Met* status.
b. A detailed review of the survey eligibility file elements to ensure the accuracy of the file layout against required file specifications, and the measure specific eligibility flags (i.e. flu flag, prescreen status code designations) were present as applicable.
c. Evaluation of membership data completeness (address, telephone fields).
d. Validation that **Kaiser QUEST** selected a certified CAHPS vendor to administer the appropriate survey(s).

Upon completion of the validation process, the auditor reviewed and locked the NCQA Sample Frame Validation Tool (Appendix B) and provided the locked tool to the plan.

9. Detailed review of a select set of 6 measures required for reporting by the State of Hawaii, Department of Human Services, Med-QUEST Division, including those listed in Table 2-2.

Table 2-2—Audited HEDIS Measures

Measure	Product Lines
Childhood Immunization Status	Medicaid
Breast Cancer Screening	Medicaid
Chlamydia Screening in Women	Medicaid
Cholesterol Management for Patients with Cardiovascular Conditions	Medicaid
Comprehensive Diabetes Care	Medicaid
Ambulatory Care (ER Visits/1000)	Medicaid
Total Measures: 6	

Supplemental Database Review and Findings

The HEDIS 2010 Technical Specifications allow health plans to include supplemental data in the collection and calculation of the HEDIS measures, provided the NCQA rules and guidelines for collection, validation, and use of these data are followed. Supplemental data is defined as any health care delivery information that is available outside of the health plan's claims/encounter data system. Auditors must categorize the supplemental data as external (provided by an external party) or internal (generated within the health plan), and standard (provided in a standardized well-documented format) or non-standard (formats differ from source to source). HSAG determined if **Kaiser QUEST** used any supplemental data and if used, performed the following review activities:

- Review of policies and procedures for collection and validation of the data
- Review of the data format and data elements
- Primary source verification of a randomly selected sample of records against the original source of the data

The results of this review are presented in Table 2-3 below.

Table 2-3—Supplemental Database Findings

Database Name	External/Internal	Standard/Non-Standard	Measures Impacted	Primary Source Verification Required?	Results
Spectra Labs	External	Standard	Lab measures	No, but reviewed Kaiser QUEST's medical record validation.	Spectra Labs only sees members who are on dialysis. Very few QUEST members are included in this data and those who are included are excluded from CDC due to ESRD. Kaiser QUEST performed a medical record validation of this data for 2009, with a 100% accuracy rate from Spectra Labs.

3. Information Systems Capabilities Assessment
for Kaiser Permanente QUEST

Introduction

The audit team reviewed **Kaiser QUEST's** IS capabilities for accurate HEDIS reporting. The audit team focused specifically on aspects of **Kaiser QUEST's** systems that could impact the HEDIS reporting set.

For the purpose of HEDIS Compliance Auditing, the term "information systems" was used broadly to include **Kaiser QUEST's** computer and software environment, data collection procedures, applicable supplemental databases, and abstraction of medical records for hybrid measures. In addition, the IS evaluation included a review of any manual processes that may have been used for HEDIS reporting. In summary, the audit team determined if **Kaiser QUEST** had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

In accordance with the 2010 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, Volume 5, the audit team evaluated **Kaiser QUEST's** IS compliance with NCQA's IS standards, which detail the minimum requirements that should be met, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the audit team evaluated the impact on HEDIS reporting capabilities. An MCO may not be fully compliant with many of the IS standards, but may be fully able to report all measures.

Please note that there are certain IS standards that address data (for example, mental health services) that are required for the full HEDIS reporting set, but are not specifically required for the selected core set measures (if applicable). The auditors' evaluation of **Kaiser QUEST's** IS capabilities is, therefore, more comprehensive than the processes required to produce the selected measures.

The section that follows is a summary of **Kaiser QUEST's** compliance with NCQA's IS standards. A listing of each IS standard, followed by its rationale regarding accurate HEDIS reporting, is located in Appendix A of this report.

Summary of Key Audit Findings/Compliance With IS Standards

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

Kaiser QUEST is compliant with this standard. **Kaiser QUEST** receives a small amount of claims data that is processed through the KPOPS system. KPHC (HealthConnect, which is front-end, and Chronicles, which is back-end) is used to process internal encounters, which accounts for 98 percent of its total volume. Sufficient edits are in place in both systems to ensure codes are valid and complete. The volume of audited data for KPOPs may be a little low, but these are mainly ED and hospitals outside **Kaiser QUEST** and, therefore, there is little impact on the actual HEDIS measures under review. **Kaiser QUEST** also has numerous internal service codes, which are fully crosswalked to industry standard codes and this crosswalk was reviewed and approved by the auditor. **Kaiser QUEST's** internal providers complete their encounters for every kept appointment in HealthConnect, which helps to ensure that the encounter data are complete.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

Kaiser QUEST is compliant with this standard. Members were identified in **Kaiser QUEST's** system through the use of a unique identification number (health record number), as well as the Quest ID number. **Kaiser QUEST's** Hawaii staff is responsible for downloading the daily files from MedQUEST (MQD) and (Consolidated Service Center processes these files. The enrollment files are reconciled against the State files and the data entry of enrollment information is reconciled with the electronic enrollment files downloaded in Hawaii. There were no identified issues related to file quality or timeliness.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

Kaiser QUEST is compliant with this standard. **Kaiser QUEST** is able to determine the rendering provider, appropriate provider type, and specialties for HEDIS reporting.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

Kaiser QUEST is fully compliant with IS 4.0. The health plan does not use certified software. Internal staff collects medical record documentation via the plan's centralized EMR and data enters the information into a standardized spreadsheet. **Kaiser QUEST** is performing medical record review for childhood immunizations, and Comprehensive Diabetes Care. **Kaiser QUEST's** tools have front end edits that do not allow entry of data that is out of the appropriate date ranges for the measures and checks for duplicate data within 14 days. The tool is pre-populated with encounter data. Once completed, the tool contains the full set of data for the measure. The processes in place for training, procurement, abstraction, IRR and data entry were sufficient to ensure reliability of the data collected. There were no changes to the medical record review process; therefore, a convenience sample was not required. **Kaiser QUEST** passed the over-read requirement for the following two measures: Comprehensive Diabetes Care - Eye Exam and Comprehensive Diabetes Care - Medical Attention for Nephropathy.

IS 5.0—Supplemental Data—Capture, Transfer and Entry

Kaiser QUEST is compliant with this standard. **Kaiser QUEST** receives lab data from Spectra labs on a daily basis. This file comes through in a standard HL-7 format. The file primarily includes data on ESRD patients on dialysis, but some additional lab data are received as well. There were no issues with receiving the data in 2009 and **Kaiser QUEST** performed a medical record review of the data to ensure accuracy, which is an excellent validation step. For the HEDIS measures under review, **Kaiser QUEST** does not expect to have any hits from this data, since these members would most likely be excluded due to ESRD. Therefore, the supplemental data is compliant, but not applicable.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

IS 6.0 was not applicable to the measures under the scope of the Hawaii Medicaid audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Kaiser QUEST is compliant with this standard. Several data systems are used for HEDIS. Data from each system is validated and audit checks are in place to ensure the data was fully loaded. Reasonability checks are also performed on the data to ensure data are clean. **Kaiser QUEST** writes their own source code. Only minor issues were determined -mainly source code reviewers were lacking the data crosswalk for homegrown **Kaiser QUEST** codes. These were provided following the onsite audit. Since source code review was not complete at the time of the onsite visit, primary source verification was conducted after the onsite audit, and no issues were identified.

4. Medical Record Review Validation Findings

for Kaiser Permanente QUEST

Introduction

To validate the medical record review (MRR) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the MCO, including staff qualifications, training, data collection instruments/tools, interrater reliability (IRR) testing, and the method used for combining MRR data with administrative data; and (2) reabstract and compare the audit team's results to the MCO's abstraction results for a selection of hybrid measures.

HSAG's audit team reviewed the processes in place at **Kaiser QUEST** for performance of MRR for all measures reported using the hybrid method. Data collection tools and training materials were reviewed by the audit team to verify that all key HEDIS data elements were captured. Feedback was provided to **Kaiser QUEST's** staff if the data collection tools appeared to be missing necessary data elements. The audit team determined that **Kaiser QUEST's** processes for IRR testing met standards. Additional audit findings related to MRR processes are located under IS Standard 4.0 of the Summary of Key Audit Findings/Compliance With IS Standards.

HSAG's audit team also performed a reabstraction of records selected for MRRs and compared the results to **Kaiser QUEST's** findings for the same medical records. This process completed the medical record validation process and provided an assessment of actual reviewer accuracy. HSAG reviewed up to 30 records identified by **Kaiser QUEST** as meeting numerator event requirements (determined through MRR) for measures selected for audit and MRR validation. Records were randomly selected from the entire population of MRR numerator positives identified by the MCO, as indicated on the MRR numerator listings submitted to the audit team. If fewer than 30 medical records were found to meet numerator requirements, all records were reviewed. Reported discrepancies only included "critical errors," defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa).

For each of the selected measures where the hybrid methodology was used, auditors determined the impact of the findings from the validation process on the MCO's audit designation. The goal of the MRR validation was to determine whether the MCO made abstraction errors that significantly biased its final reported rate. HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCOs. The NCQA-endorsed t-test was employed to test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If the test revealed that the difference was greater than 5 percent, the MCO's estimate of the positive rate was rejected and the measure could not be reported using the hybrid methodology.

Table 4-1 identifies the measure name, the MCO product line, the number of records overread, and the t-test results with the corresponding pass/fail determination.

Table 4-1—Selected HEDIS Measures for Medical Record Validation				
Measure	**Product Line**	**Number of Records Overread**	**T-test Results**	**Pass/Fail**
Comprehensive Diabetes Care - Medical Attention for Nephropathy	Medicaid	9	N/A	Pass
Comprehensive Diabetes Care - Eye Exam	Medicaid	30	N/A	Pass

Introduction

Each of the audited measures reviewed by the audit team received a final audit result consistent with the NCQA categories listed below. HSAG used a variety of audit methods, including analysis of computer programs, medical record abstraction results, data files, samples of data, and staff interviews to make each measure-specific result. Table 5-1 provides the audit finding results that are applicable to the HEDIS measures.

Table 5-1—Audit Results

Rate/Result	Comment
0-XXX	Reportable rate or numeric result for HEDIS measures.
NR	**Not Reported:** 1. Plan chose not to report 2. Calculated rate was materially biased 3. Plan not required to report
NA	**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 (e.g., mental health or chemical dependency)

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (for example, *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible that **Kaiser QUEST** prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, **Kaiser QUEST** would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive an "NR" result in the data submission worksheet, where appropriate.

Appendix C of this report contains the final audited data submission worksheet, which displays the audit result for each reported measure, the rationale for the assigned result, and any additional comments. The audit result signifies which rates are appropriate for inclusion in external reports.

Final Audit Statement

We have examined **Kaiser QUEST** submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS Technical Specifications for all measures presented at the time of our audit.

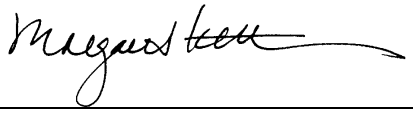
This report is **Kaiser QUEST** management's responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submission presents fairly, in all material respects, the organization's performance with respect to the *HEDIS Technical Specifications*. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the organization.

In our opinion, **Kaiser QUEST's** submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity, and enforceability as original signatures submitted on paper.

David Mabb, MS, CHCA
(NCQA-Certified HEDIS Compliance Auditor)

July 15, 2010
(Date)



Margaret Ketterer, RN, BSN, CHCA
(Responsible Officer)

July 15, 2010
(Date)

Organization ID: 124

Submission ID(s): 4019

APPENDIX A. INFORMATION SYSTEMS STANDARDS
for Kaiser Permanente QUEST

Source: NCQA 2010 *HEDIS® Compliance Audit™: Standards, Policies, and Procedures,* Volume 5.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

IS 1.1 Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) are used and all characters are captured.

- Data submission documents and transaction files include industry standard codes with full character levels
- Claims and encounter data entry screens allow entry of all codes and characters
- Data entry processors enter all codes and characters
- Policy and procedure manuals document that codes cannot be altered or deleted and that default codes are not used or are mapped correctly

IS 1.2 Principal codes are identified and secondary codes are captured.

- Data submission documents and transaction files differentiate principal codes from secondary codes
- Claims and encounter data entry screens allow entry of all principal and secondary codes
- Data entry processors enter all principal and secondary codes accurately

IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the HEDIS requirements in the Volume 2 General Guidelines
- Program code ensures that mapping documents are executed accurately

IS 1.4 Standard submission forms are used and capture all fields relevant to HEDIS reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.

- Standard and nonstandard forms have policies, procedures and completion instructions to verify that all fields relevant to HEDIS reporting are included
- Nonstandard submission forms include required data and capture all:
  - Codes
  - Characters for all codes
  - Data fields listed in the HEDIS Roadmap for the appropriate claims system

- Electronic file formats are consistent with industry standard forms and capture all data fields listed in the HEDIS Roadmap for the appropriate claims system
- Policies and procedures for submitting information on electronic forms verify:
  - The organization effectively monitors the quality and accuracy of electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 1.5 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for HEDIS reporting.

- Claims and encounter data entry screens display:
  - Edit checks for parity, field sizes, date ranges, code ranges
  - Cross checks with member and practitioner files
  - All data fields listed in the appropriate claims section of the HEDIS Roadmap
- Reports for claim/encounter processing staff and hardware operations verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of the entry processes (refer to Roadmap Attachment 1.4)
- Flowcharts clearly describe claim and encounter processing from all sources (refer to Roadmap Attachment 1.1)
- Policies and procedures and training manuals for data submission and entry ensure accuracy and completeness
- Data transaction files confirm accuracy, including:
  - Comparison of a sample of data entry files with source documents to ensure that all data are entered and are not changed or deleted during processing
  - Capture of denied claims for HEDIS reporting

IS 1.6 The organization continually assesses data completeness and takes steps to improve performance.

- The organization's data completeness studies help determine their impact on HEDIS reporting (refer to Roadmap Attachment 1.5)
- Payment arrangements for all providers show their impact on HEDIS reporting (refer to Roadmap Table 1.14)
- Policies, procedures and performance standards require complete submission of claims or encounter data from all practitioners to assess data completeness

IS 1.7 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors confirm that the organization:
  - Requires data for HEDIS reporting
  - Provides inspection and onsite auditing of data, correction and resubmission of data
  - Has backlog control standards and procedures and enforces quality standards
- Studies and reports are used to:
  - Determine that claim and encounter data from vendors are complete and accurate
  - Ensure that no data are lost or modified during transfer among vendors

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 2.0—Enrollment Data—Data Capture, Transfer and Entry

IS 2.1 The organization has procedures for submitting HEDIS-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization
- Forms used by employers for additions, deletions and changes—including samples of completed forms, policies, procedures and instructions for completing membership forms—ensure that all fields relevant to HEDIS reporting are included (refer to Roadmap Table 2.2)
- Electronic file formats and protocols ensure capture of all data fields listed in the HEDIS Roadmap Table 2.2
- Policies and procedures for submitting and transmitting electronic information should include evidence that:
  - The organization effectively monitors the quality and accuracy of its electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all membership operations personnel—including data entry, membership processing staff and hardware operations—verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of its entry processes
- Flowcharts describe membership processing from all sources (refer to Roadmap Attachment 2.1)
- Data entry processors enter all required HEDIS data elements (refer to Roadmap Table 2.2).
- Data entry policies and procedures and training manuals ensure accuracy and completeness
- Membership data entry screens have:
  - Proper edit checks for parity, field sizes, date ranges, code ranges, practitioner services by specialty and cross checks with member and practitioner files
  - All data fields listed in the HEDIS Roadmap Table 2.2
- Data transaction files are accurate, including:
  - Comparison of a sample of data-entry files with source documents to ensure that all data are entered and are not changed or deleted during processing
  - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and are not changed or deleted during processing

IS 2.3 The organization continually assesses data completeness and takes steps to improve performance.

- The organization's membership system can accommodate:
  - Changes in family status
  - Changes in employment
  - Changes in product line
  - Changes in product
  - Methods for defining coverage start and end
  - Multiple membership status changes, including membership periods and disenrollment information
- Policies, procedures and performance standards require:
  - Complete submission and entry of membership data
  - Proper control of transmissions through logs, record count verification, redundancy checking receipts, retransmissions and sign-offs
- Policies, procedures and performance standards:
  - Require complete submission of data to ancillary vendors
  - Describe the process for submitting data to ancillary vendors and how often data are submitted
  - Describe the data oversight process for the ancillary vendor

IS 2.4 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for HEDIS reporting and provide inspection and onsite auditing of data; correction and resubmission of data and backlog control standards and procedures; and enforce quality standards
- Studies and reports show that:
  - Membership level data from vendors are complete and accurate
  - No data are lost or modified during transfer

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 3.0—Practitioner Data—Data Capture, Transfer and Entry

IS 3.1 Provider specialties are fully documented and mapped to HEDIS provider specialties.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the HEDIS requirements in the Volume 2 *General Guidelines*
- Program code ensures that mapping documents are executed accurately

IS 3.2 The organization has effective procedures for submitting HEDIS-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization
- Forms used to process practitioner additions, deletions and changes—including samples of completed forms, policies, procedures and instructions for completing the forms—ensure that all fields relevant to HEDIS reporting are included (refer to Roadmap Tables 3A.2, 3B.3)
- Electronic file formats and protocols ensure capture of all data fields listed in HEDIS Roadmap Tables 3A.2 and 3B.3, including credentialing dates
- Policies and procedures for submission and transmission of electronic information ensure:
  - The organization effectively monitors the quality and accuracy of its electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 3.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all provider operations personnel—including data entry, provider processing staff and hardware operations—verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of its entry processes
- Flowcharts describe provider processing from all sources (refer to Roadmap Attachment 3A.1, 3B.2)
- Data entry processors enter all required HEDIS data elements (refer to Roadmap Tables 3A.2, 3B.3) in both the claims processing system and the provider credentialing system
- Data entry policies and procedures and training manuals ensure accuracy and completeness
- Provider claims processing and provider credentialing data entry screens have:
  - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claims/ encounter and practitioner file, code ranges and practitioner services by specialty
  - All data fields listed in the HEDIS Roadmap (refer to Table 3A.2, 3B.3)

- Data transaction files and provider credentialing files are accurate, including:
  - Comparison of a sample of data entry files with source documents to ensure that all data are entered and that data are not changed or deleted during processing
  - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and that data are not changed or deleted during processing

IS 3.4 The organization continually assesses data completeness and takes steps to improve performance.

- Policies, procedures and performance standards require:
  - Complete submission and entry of provider data
  - Proper control of transmissions through logs, record count verification, redundancy checking receipts, retransmissions and sign-offs
- Policies, procedures and performance standards require reconciliation of data:
  - Between the credentialing and claims processing systems
  - Between the credentialing and the claims processing systems used by external entities

IS 3.5 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for HEDIS reporting and provide inspection and onsite auditing of data; correction and resubmission of data and backlog control standards and procedures; and enforce quality standards
- Studies and reports show that:
  - Practitioner level data from vendors are complete and accurate
  - No data are lost or modified during transfer

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction and Oversight

IS 4.1 Forms capture all fields relevant to HEDIS reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).

- Forms or tools used for medical record review—including samples of completed forms, policies, procedures and instructions for completing the forms—ensure:
  - All fields relevant to HEDIS reporting are included (refer to Roadmap Attachment 4.3)
  - Forms guide the reviewer to the medical record data elements
- Electronic file formats and protocols ensure that all data fields are captured for each HEDIS measure
- Policies, procedures and program code for files used to transfer administrative data to the medical record review tools are complete and available
- Policies and procedures for submission and transmission of electronic information show:
  - The organization effectively monitors the quality and accuracy of its electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 4.2 Retrieval and abstraction of data from medical records is reliably and accurately performed.

- Policies, procedures, and training manuals (refer to Roadmap Attachment 4.4) for medical record review—including chase logic and chart retrieval—ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization
- Educational and professional credentials, including resumes or curriculum vitae, and experience of the medical record review team members
- Interrater reliability standards and results ensure medical record review is accurate and complete (refer to Roadmap Attachment 4.5)

IS 4.3 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for HEDIS reporting.

- Standard monitoring reports for all data entry operations personnel verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of its entry processes (refer to Roadmap Attachment 4.5)
- Flowcharts and timelines describe medical record review processing from all sources (refer to Roadmap Attachments 4.1, 4.2)
- Data entry processors enter all required HEDIS data elements for each measure

- Data entry policies and procedures and training manuals ensure accuracy and completeness
- Medical record review data entry screens have:
  - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claims/ encounter and practitioner file, code ranges and practitioner services by specialty
  - All necessary data fields for each measure
- Data transaction files are accurate, including:
  - Comparison of a sample of data entry files with source documents to ensure that all data are entered and that data are not changed or deleted during processing
  - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and that data are not changed or deleted during processing
- The convenience sample, if applicable, ensures that the medical record review process begins accurately
- Medical record review validation verifies that the medical record review process worked as planned

IS 4.4 The organization continually assesses data completeness and takes steps to improve performance.

- Tracking documents indicate the progress of the medical record review and the number of numerator-compliant members and exclusions
- Policies and procedures and performance standards require:
  - Complete submission and entry of medical record data
  - Transmissions to be properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 4.5 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for HEDIS reporting and provide inspection and onsite auditing of data; correction and resubmission of data and backlog control standards and enforce quality standards
- Studies and reports show that:
  - Data from vendors are complete and accurate
  - No data are lost or modified during transfer

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 5.0—Supplemental Data—Capture, Transfer and Entry

IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the HEDIS requirements in the Volume 2 *General Guidelines*
- Program code ensures that mapping documents are executed accurately

IS 5.2 The organization has effective procedures for submitting HEDIS-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization
- Forms—including samples of completed forms, policies, procedures and instructions for completing the forms—ensure that all fields relevant to HEDIS reporting are included (refer to Roadmap Table 5.1)
- Electronic file formats and protocols ensure capture of all data fields listed in the HEDIS Roadmap (refer to Table 5.1, Attachment 5.1)
- Policies and procedures for collecting supplemental data specify:
  - Exclusions are not collected for previous reporting years for members with clinical conditions that can change
  - Information obtained by the provider's office or clinician directly from the member was entered in the medical record by the deadline established for the measure
  - Information obtained by the provider's office or clinician directly from the member is verified when taking a patient history of a disease management system
  - Information obtained from a simple provider attestation is not used
  - Information obtained from member surveys is not used
- Policies and procedures for submission and transmission of electronic information:
  - The organization effectively monitors the quality and accuracy of its electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs

IS 5.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all personnel—including data entry, provider processing staff and hardware operations—verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of its entry processes (refer to Roadmap Attachment 5.3, 5.4)

- Flowcharts describe data from all sources
- Data entry processors enter all required HEDIS data elements (refer to Roadmap Table 5.1)
- Policies and procedures and training manuals for data entry ensure accuracy and completeness
- Data entry screens have:
  - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claim/ encounter and practitioner files, code ranges and practitioner services by specialty
  - All data fields listed in HEDIS Roadmap Table 5.1
- Data transaction files are checked for accuracy, including:
  - Comparison of a sample of data entry files with source documents to ensure that all data are entered and are not changed or deleted during processing
  - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and are not changed or deleted during processing

IS 5.4 The organization continually assesses data completeness and takes steps to improve performance.

- Policies, procedures and performance standards require:
  - Complete submission and entry of data
  - Proper control of transmissions by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs to ensure that all data are received
- Contracts with vendors require data for HEDIS reporting and provide inspection and onsite auditing of data, correction and resubmission of data and backlog control standards and procedures
- Policies, procedures and performance standards require reconciliation of data between the originating system and the repository

IS 5.5 The organization regularly monitors vendor performance against expected performance standards.

- Documentation acquired by the organization shows that the responsible agency has reasonable processes in place for data collection and accuracy
- Studies and reports show that:
  - Data from vendors are complete and accurate
  - No data are lost or modified during transfer

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 6.0—Member Call Center Data—Capture, Transfer and Entry

IS 6.1 Member call center data are reliably and accurately captured.

- Documentation demonstrates:
  - Types of call processed
  - Product or product lines affected
  - Parameters on the ACD system (refer to Roadmap attachment 6.3)
  - ACD system flow (refer to Roadmap attachment 6.1)
  - Call volume (refer to Roadmap attachment 6.2)

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

IS 7.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the HEDIS requirements in the Volume 2 *General Guidelines*
- Program code ensures that mapping documents are executed accurately

IS 7.2 Data transfers to HEDIS repository from transaction files are accurate.

- Standard monitoring reports for all operations personnel, including IS staff and hardware operations verify that the organization effectively monitors the quality, and accuracy of its processes
- Flowcharts describe data from all sources (Roadmap attachment 7.1)
- HEDIS repository data entry and data transfer processes produce the intended result
- Policies and procedures document building, maintaining, testing and reporting for the HEDIS reporting repository
- Data samples from transaction files and medical record abstraction are compared with the HEDIS repository to ensure accurate procedures for populating the repository
- HEDIS repository edits lists explain all edit failures
- Electronic file formats and protocols ensure capture of all data fields
- Policies and procedures for submission and transmission of electronic information show:
  - The organization effectively monitors the quality and accuracy of its electronic submissions
  - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs
- Training materials and procedure manuals for operator staff ensure accuracy and completeness

IS 7.3 File consolidations, extracts and derivations are accurate.

- HEDIS repository data manipulation programs and processes produce the intended result, including programs that consolidate information from multiple transaction files
- Flowcharts describe data from all sources
- Mechanisms link data across all data sources to satisfy HEDIS data integration requirements
- Data entry screens show all data are captured

IS 7.4 Repository structure and formatting are suitable for HEDIS measures and enable required programming efforts.

- The repository design ensures that it can accommodate analysis that produces HEDIS results (refer to Roadmap attachment 7.2). Documents available for review include:
  - Record and file formats
  - Descriptions for entry and intermediate files

IS 7.5 Report production is managed effectively and operators perform appropriately.

- Policies, procedures and dated job logs govern the production process
- Report run controls are reviewed by operators

IS 7.6 HEDIS reporting software is managed properly with regard to development, methodology, documentation, revision control and testing.

- HEDIS repository manuals cover the application system development methodology, database development and design and the decision support system used to validate proper controls
- Report documentation, including code review methodology and testing, meets industry standards
- Programming specifications, work flow diagrams, data sources and diagrams or narrative descriptions meet industry standards
- A list of measures indicates the programmer responsible for each measure (refer to Roadmap attachment 7.5)

IS 7.7 Physical control procedures ensure HEDIS data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection.

- HEDIS repository computer operations and system security schemes, documentation and procedures ensure that data are not compromised by physical security, data access authorization, disaster recovery procedures, power failures, fire or smoke (refer to Roadmap attachment 7.6).
- Adequate copies of the repository and documentation are maintained
- Policy, procedures, and log forms for monitoring control, security hardware functions, hardware activities, back-ups, recovery, archiving, capacity, physical states and access are available for review

Software Certification

If the software vendor maintains a repository, documents describing the repository structure are included with the HEDIS Roadmap. The link mechanisms and analysis code are tested as part of the software certification program

If the organization uses NCQA-Certified software, this information is included in the vendor's portions of the HEDIS Roadmap. The organization and auditor must discern the appropriate version of software was used to produce the HEDIS results.

APPENDIX B. CAHPS SAMPLE FRAME VALIDATION TOOL
for Kaiser Permanente QUEST

CAHPS Sample Frame Validation Tool for Kaiser QUEST

Appendix B contains the final locked and audited CAHPS Sample Frame Validation Tool for **Kaiser QUEST**.

Appendix B. CAHPS Sample Frame Validation

CAHPS Sample Frame Information	
The health plan completes all sections shaded blue. Complete the appropriate tabs for the product lines/products being reported.	
Total number of CAHPS sample frame data files	***1***
Date sample frame due to Auditor	***12/21/2009***
Date sample frame due to Survey Vendor	***1/27/2010***

Health Plan Contact Information	
Name	Patricia M. Bazin
Title	Health Care Services Branch Administator
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HEDIS Survey Vendor Contact Information	
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HEDIS Compliance Auditor Contact Information	
Name	Peggy Ketterer
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Company	Health Services Advisory Group, Inc.
Address	1600 E. Northern Avenue, Suite 100
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Telephone	602-745-6322
Fax	602-241-0757
E-mail address	pketterer@hsag.com

CAHPS Sample Frame Information

Complete the information for each product, adding columns when necessary.
Columns should reflect the exact product line/product combination as defined by the HEDIS reporting entity.

The health plan completes all sections shaded blue for each HEDIS reporting entity.
The auditor completes all sections shaded green for each HEDIS reporting entity.

	Product A	Product B	Product C	Product D	Product E
Product	HMO	Select one	Select one	Select one	Select one
Product Name	Kaiser Permanente QUEST				
Prior years Org ID	124				
Prior year's Sub ID	4019				
Membership on 12/31/measurement year	8155				
Adult Sample Frame Filename	Kaiser II.txt				
Survey Vendor Tracking ID (adult submission)					
Child Sample Frame Filename					
Survey Vendor Tracking ID (child submission)					
Survey methodology	mail with telephone	Select one	Select one	Select one	Select one

What survey measures do you intend to report?		Product A		Product B		Product C		Product D		Product E	
CPA	CAHPS Health Plan Survey 4.0H, Adult Version	Reporting	Supports report	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results
ASP	Aspirin Use and Discussion	Not reporting	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results
MSC	Medical Assistance With Smoking Cessation	Not reporting	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results
CPC	CAHPS Health Plan Survey 4.0H, Child Version	Not reporting	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results
CCC	Children with Chronic Conditions	Not reporting	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results	Select one	Enter Results

Note: The HEDIS Compliance Auditor may elect to customize the tool by adding rows below. To maintain standardization of the tool, rows may not be added above this row (row 23).

Final Data Submission for Kaiser QUEST

Appendix C contains the final audited data submission worksheet and audit designations for **Kaiser QUEST**.

Ambulatory Care (AMBA)		
Age	Member Months	
<1	13,682	
1-9	93,077	
10-19	70,859	
20-44	61,836	
45-64	18,945	
65-74	0	
75-84	0	
85+	0	
Unknown	0	
Total	258,399	

Age	ED Visits	
	Visits	Visits/ 1,000 Member Months
<1	676	49.41
1-9	2321	24.94
10-19	1323	18.67
20-44	2334	37.75
45-64	727	38.37
65-74	0	0
75-84	0	0
85+	0	0
Unknown	0	0
Total	7,381	28.56

Breast Cancer Screening (BCS)	
Data Element	**General Measure Data**
HEDIS Reporting Year	2010
Data collection methodology (administrative)	A
Eligible population	693
Numerator events by administrative data	536
Reported rate	77.34%
Lower 95% confidence interval	74.16%
Upper 95% confidence interval	80.53%

Comprehensive Diabetes Care (CDC)										
Data Element	**HbA1c Testing**	**HbA1c Poor Control (>9.0%)**	**HbA1c Control (<8.0%)**	**HbA1c Control (<7.0%)**	**Eye Exam**	**LDL-C Screening**	**LDL-C Level <100 mg/dL**	**Medical Attention for Nephropathy**	**Blood Pressure Controlled <130/80 mm Hg**	**Blood Pressure Controlled <140/90 mm Hg**
HEDIS Reporting Year	2010	2010	2010	2010	2010	2010	2010	2010	2010	2010
Data collection methodology (administrative or hybrid)	H	H	H	H	H	H	H	H	H	H
Eligible population	469	469	469	426	469	469	469	469	469	469
Number of numerator events by administrative data in eligible population (before exclusions)	408	237	176	89	287	378	187	368	240	355
Current year's administrative rate (before exclusions)	86.99%	50.53%	37.53%	20.89%	61.19%	80.60%	39.87%	78.46%	51.17%	75.69%
Minimum required sample size (MRSS) or other sample size	469	469	469	426	469	469	469	469	469	469
Oversampling rate	0	0	0	0	0	0	0	0	0	0
Final sample size (FSS)	469	469	469	426	469	469	469	469	469	469
Number of numerator events by administrative data in FSS	408	237	176	89	287	378	187	368	240	355
Administrative rate on FSS	86.99%	50.53%	37.53%	20.89%	61.19%	80.60%	39.87%	78.46%	51.17%	75.69%
Number of original sample records excluded because of valid data errors	0	0	0	0	0	0	0	0	0	0
Number of administrative data records excluded	0	0	0	0	0	0	0	0	0	0
Number of medical data records excluded	24	24	24	24	24	24	24	24	24	24
Number of employee/dependent medical records excluded	0	0	0	0	0	0	0	0	0	0
Records added from the oversample list	0	0	0	0	0	0	0	0	0	0
Denominator	445	445	445	402	445	445	445	445	445	445
Numerator events by administrative data	391	230	160	74	283	375	187	368	228	336
Numerator events by medical records	2	0	0	0	55	4	2	8	3	5
Reported rate	88.31%	51.69%	35.96%	18.41%	75.96%	85.17%	42.47%	84.49%	51.91%	76.63%
Lower 95% confidence interval	85.22%	46.93%	31.38%	14.50%	71.87%	81.75%	37.77%	81.02%	47.16%	72.58%
Upper 95% confidence interval	91.41%	56.44%	40.53%	22.32%	80.04%	88.58%	47.18%	87.97%	56.66%	80.67%

Chlamydia Screening in Women (CHL)				
Data Element	**General Measure Data**	**16-20 years**	**21-24 years**	**Total**
HEDIS Reporting Year	2010			
Data collection methodology (administrative)	A			
Eligible population		537	546	1083
Numerator events by administrative data		390	418	808
Reported rate		72.63%	76.56%	74.61%
Lower 95% confidence interval		68.76%	72.91%	71.97%
Upper 95% confidence interval		76.49%	80.20%	77.25%

Childhood Immunization Status (CIS)										
Data Element	**General Measure Data**	**DTaP**	**IPV**	**MMR**	**HiB**	**Hepatitis B**	**VZV**	**Pneumo-coccal Conjugate**	**Combo 2 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV)**	**Combo 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV, Pneumo-coccal Conjugate)**
HEDIS Reporting Year	2010									
Data collection methodology (administrative or hybrid)	H									
Eligible population	874									
Number of numerator events by admin data in eligible population (before exclusions)		787	837	824	842	836	820	778	770	749
Current year's administrative rate (before exclusions)		90.05%	95.77%	94.28%	96.34%	95.65%	93.82%	89.02%	88.10%	85.70%
Minimum required sample size (MRSS) or other sample Size	411									
Oversampling rate	0.05									
Final sample size	432									
Number of numerator events by admin data in FSS		387	409	405	414	409	403	381	380	370
Administrative rate on FSS		89.58%	94.68%	93.75%	95.83%	94.68%	93.29%	88.19%	87.96%	85.65%
Number of original records excluded because of valid data errors	0									
Number of administrative data records excluded	0									
Number of medical data records excluded	0									
Number of employee/dependent medical records excluded	0									
Records added from the oversample list	0									
Denominator	411									
Numerator events by administrative data		369	390	386	394	389	384	365	362	354
Number of numerator events by medical records		0	0	0	0	2	0	0	2	2
Reported rate		89.78%	94.89%	93.92%	95.86%	95.13%	93.43%	88.81%	88.56%	86.62%
Lower 95% confidence interval		86.73%	92.64%	91.48%	93.82%	92.93%	90.91%	85.64%	85.37%	83.20%
Upper 95% confidence interval		92.83%	97.14%	96.35%	97.91%	97.34%	95.95%	91.98%	91.76%	90.03%

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)				
Data Element	**General Measure Data**	**LDL-C Screening**	**LDL-C level <100 mg/dL**	
HEDIS Reporting Year	2010			
Data collection methodology (administrative or hybrid)	A			
Eligible population	25			
Number of numerator events by administrative data in eligible population (before exclusions)		21	10	
Current year's administrative rate (before exclusions)		84.00%	40.00%	
Minimum required sample size (MRSS) or other sample size				
Oversampling rate				
Final sample size (FSS)				
Number of numerator events by administrative data in FSS				
Administrative rate on FSS		#DIV/0!	#DIV/0!	
Number of original sample records excluded because of valid data errors	0			
Number of employee/dependent medical records excluded	0			
Records added from the oversample list	0			
Denominator	25			
Numerator events by administrative data		21	10	
Numerator events by medical records		0	0	
Reported rate		84.00%	40.00%	***Not officially reported due to small numbers.***
Lower 95% confidence interval		67.63%	18.80%	
Upper 95% confidence interval		100.37%	61.20%	

Audit Review Table		
Measure/Data Element	**Reportable**	**Comment**
Childhood Immunization Status (cis)		
DTaP	R	Reportable Rate
IPV	R	Reportable Rate
MMR	R	Reportable Rate
HiB	R	Reportable Rate
Hepatitis B	R	Reportable Rate
VZV	R	Reportable Rate
Pneumococcal Conjugate	R	Reportable Rate
Combination #2	R	Reportable Rate
Combination #3	R	Reportable Rate
Breast Cancer Screening (bcs)	R	Reportable Rate
Chlamydia Screening in Women (chl)		
16-20 Years	R	Reportable Rate
21-24 Years	R	Reportable Rate
Total	R	Reportable Rate
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)		
LDL-C Screening Performed	NA	Eligible population <30
LDL-C Control (<100 mg/dL)	NA	Eligible population <30
Comprehensive Diabetes Care (cdc)		
Hemoglobin A1c (HbA1c) Testing	R	Reportable Rate
HbA1c Poor Control (>9.0%)	R	Reportable Rate
HbA1c Control (<8.0%)	R	Reportable Rate
HbA1c Control (<7.0%)	R	Reportable Rate
Eye Exam (Retinal) Performed	R	Reportable Rate
LDL-C Screening Performed	R	Reportable Rate
LDL-C Control (<100 mg/dL)	R	Reportable Rate
Medical Attention for Nephropathy	R	Reportable Rate
Blood Pressure Control (<130/80 mm Hg)	R	Reportable Rate
Blood Pressure Control (<140/90 mm Hg)	R	Reportable Rate
Ambulatory Care: ER Visits/1000	R	Reportable Rate

Audit Review Table			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec A			
This submission is unlocked			
Measure/Data Element	**Report Measure**	**Benefit Offered**	**Rotated Measure**
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		N
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			

Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-50 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			
Blood Pressure Control (<130/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			

45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			
12-19 Years			
Annual Dental Visit (adv)	N	N	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	Y	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		Y
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Call Abandonment (cab)	Y		
Use of Services			
Frequency of Ongoing Prenatal Care (fpc)	Y		Y
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	N		
Ambulatory Care: Disabled (ambc)	N		
Ambulatory Care: Other (ambd)	N		

Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N		
Inpatient Utilization--Nonacute Care: Total (nona)	Y		
Inpatient Utilization--Nonacute Care: Dual Eligibles (nonb)	N		
Inpatient Utilization--Nonacute Care: Disabled (nonc)	N		
Inpatient Utilization--Nonacute Care: Other (nond)	N		
Identification of Alcohol and Other Drug Services: Total (iada)	Y	Y	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	N	N	
Mental Health Utilization: Disabled (mptc)	N	N	
Mental Health Utilization: Other (mptd)	N	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	N	N	
Antibiotic Utilization: Disabled (abxc)	N	N	
Antibiotic Utilization: Other (abxd)	N	N	
Outpatient Drug Utilization: Total (orxa)	Y	Y	
Outpatient Drug Utilization: Dual Eligibles (orxb)	N	N	
Outpatient Drug Utilization: Disabled (orxc)	N	N	
Outpatient Drug Utilization: Other (orxd)	N	N	
Cost of Care			
Relative Resource Use for People With Diabetes (rdi)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Asthma (ras)	Y	Y	
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			

E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Acute Lower Back Pain (rlb)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
MRIs per 1,000 Member Years			
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Hypertension (rhy)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With COPD (rco)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Enrollment by Product Line: Total (enpa)	Y		

Enrollment by Product Line: Dual Eligibles (enpb)	N		
Enrollment by Product Line: Disabled (enpc)	N		
Enrollment by Product Line: Other (enpd)	N		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment in MCO (wop)	Y		N
Health Plan Stability			
Total Membership (tlm)	Y		

rea: None, Spec Proj: None)		
d.		
Rate	**Reportable**	**Comment**
84.62%	R	Reportable
78.35%	R	Reportable
60.34%	R	Reportable
58.39%	R	Reportable
89.78%	R	Reportable
94.89%	R	Reportable
93.92%	R	Reportable
95.86%	R	Reportable
95.13%	R	Reportable
93.43%	R	Reportable
88.81%	R	Reportable
55.96%	R	Reportable
62.53%	R	Reportable
80.78%	R	Reportable
88.56%	R	Reportable
86.62%	R	Reportable
54.01%	R	Reportable
60.34%	R	Reportable
76.89%	R	Reportable
38.20%	R	Reportable
50.12%	R	Reportable
54.50%	R	Reportable
35.77%	R	Reportable
45.74%	R	Reportable
72.51%	R	Reportable
43.55%	R	Reportable
89.93%	R	Reportable
77.34%	R	Reportable
82.57%	R	Reportable
72.63%	R	Reportable
76.56%	R	Reportable
74.61%	R	Reportable
89.57%	R	Reportable
97.70%	R	Reportable
12.05%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30

NA	R	Denominator fewer than 30
98.78%	R	Reportable
94.51%	R	Reportable
96.53%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
72.80%	R	Reportable
NA	R	Denominator fewer than 30
88.31%	R	Reportable
51.69%	R	Reportable
35.96%	R	Reportable
18.41%	R	Reportable
75.96%	R	Reportable
85.17%	R	Reportable
42.47%	R	Reportable
84.49%	R	Reportable
51.91%	R	Reportable
76.63%	R	Reportable
NA	R	Denominator fewer than 30
78.95%	R	Reportable
40.43%	R	Reportable
22.34%	R	Reportable
68.09%	R	Reportable
NA	R	Denominator fewer than 30
81.82%	R	Reportable
60.61%	R	Reportable
86.38%	R	Reportable
NA	R	Denominator fewer than 30
83.82%	R	Reportable
NA	R	Denominator fewer than 30
84.75%	R	Reportable
85.67%	R	Reportable

87.12%	R	Reportable
NA	R	Denominator fewer than 30
86.02%	R	Reportable
99.26%	R	Reportable
92.22%	R	Reportable
93.42%	R	Reportable
92.48%	R	Reportable
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
47.37%	R	Reportable
18.42%	R	Reportable
53.48%	R	Reportable
23.80%	R	Reportable
52.91%	R	Reportable
23.30%	R	Reportable
91.73%	R	Reportable
78.59%	R	Reportable
93.92%	R	Reportable
1.00%	R	Reportable
5.98%	R	Reportable
5.67%	R	Reportable
7.72%	R	Reportable
17.80%	R	Reportable
62.36%	R	Reportable
0.40%	R	Reportable
0.53%	R	Reportable
1.58%	R	Reportable
2.50%	R	Reportable
5.01%	R	Reportable
13.18%	R	Reportable
76.81%	R	Reportable
70.58%	R	Reportable
42.66%	R	Reportable
	R	Reportable
	R	Reportable
	NR	
	NR	
	NR	

	R	Reportable
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
$227.34	R	Reportable
$11.03	R	Reportable
$48.69	R	Reportable
$9.63	R	Reportable
$12.94	R	Reportable
$174.42	R	Reportable
288.66	R	Reportable
722.73	R	Reportable
$22.84	R	Reportable
$1.78	R	Reportable

$44.03	R	Reportable
$0.20	R	Reportable
$4.92	R	Reportable
$79.41	R	Reportable
52.27	R	Reportable
482.09	R	Reportable
$0.00	R	Reportable
$0.00	R	Reportable
$44.08	R	Reportable
$0.00	R	Reportable
$0.26	R	Reportable
$29.59	R	Reportable
0.00	R	Reportable
264.15	R	Reportable
301.89	R	Reportable
$324.73	R	Reportable
$20.56	R	Reportable
$73.51	R	Reportable
$19.13	R	Reportable
$13.91	R	Reportable
$241.60	R	Reportable
455.70	R	Reportable
1,822.78	R	Reportable
$289.86	R	Reportable
$10.14	R	Reportable
$50.92	R	Reportable
$17.87	R	Reportable
$13.46	R	Reportable
$77.31	R	Reportable
258.83	R	Reportable
771.00	R	Reportable
$231.93	R	Reportable
$62.10	R	Reportable
$79.75	R	Reportable
$7.12	R	Reportable
$18.65	R	Reportable
$269.58	R	Reportable
275.41	R	Reportable
786.89	R	Reportable
	R	Reportable
	R	Reportable

	NR	
	NR	
	NR	
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	

Adult BMI Assessment (ABA)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative or hybrid)	A
Eligible population	3707
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of administrative data records excluded	NR
Number of medical records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	3137
Numerator events by medical records	NR
Reported rate	84.62%
Lower 95% confidence interval	83.45%
Upper 95% confidence interval	85.80%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)									
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)									
Data Element	**BMI Percentile**			**Counseling for Nutrition**			**Counseling for Physical Activity**		
	3-11 years	**12-17 years**	**Total**	**3-11 years**	**12-17 years**	**Total**	**3-11 years**	**12-17 years**	**Total**
Measurement year	2009			2009			2009		
Data collection methodology (administrative or hybrid)	H			H			H		
Eligible population	5149	2509	7,658	5149	2509	7,658	5149	2509	7,658
Number of numerator events by administrative data in eligible population (before exclusions)	4117	1996	6,113	2236	1059	3,295	2151	1024	3,175
Current year's administrative rate (before exclusions)	79.96%	79.55%	79.83%	43.43%	42.21%	43.03%	41.78%	40.81%	41.46%
Minimum required sample size (MRSS) or other sample size	411			411			411		
Oversampling rate	.05			.05			.05		
Final sample size	432			432			432		
Number of numerator events by administrative data in FSS	228	110	338	124	53	177	119	54	173
Administrative rate on FSS	52.78%	25.46%	78.24%	28.70%	12.27%	40.97%	27.55%	12.50%	40.05%
Number of original sample records excluded because of valid data errors	0			0			0		
Number of administrative data records excluded	0			0			0		
Number of medical records excluded	0			0			0		
Number of employee/dependent medical records excluded	0			0			0		
Records added from the oversample list	0			0			0		
Denominator	273	138	411	273	138	411	273	138	411
Numerator events by administrative data	214	106	320	119	52	171	114	53	167

Numerator events by medical records	0	2	2	47	30	77	48	25	73
Reported rate	78.39%	78.26%	78.35%	60.81%	59.42%	60.34%	59.34%	56.52%	58.39%
Lower 95% confidence interval	73.32%	71.02%	74.24%	54.83%	50.87%	55.49%	53.33%	47.89%	53.51%
Upper 95% confidence interval	83.45%	85.51%	82.45%	66.78%	67.98%	65.19%	65.35%	65.16%	63.28%

Childhood Immunization Status (CIS)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None,					
Data Element	**General Measure Data**	**DTaP**	**IPV**	**MMR**	**HiB**
Measurement year	2009				
Data collection methodology (administrative or hybrid)	H				
Eligible population	874				
Number of numerator events by admin data in eligible population (before exclusions)		787	837	824	842
Current year's administrative rate (before exclusions)		90.05%	95.77%	94.28%	96.34%
Minimum required sample size (MRSS) or other sample Size	411				
Oversampling rate	.05				
Final sample size	432				
Number of numerator events by admin data in FSS		387	409	405	414
Administrative rate on FSS		89.58%	94.68%	93.75%	95.83%
Number of original records excluded because of valid data errors	0				
Number of administrative data records excluded	0				
Number of medical data records excluded	0				
Number of employee/dependent medical records excluded	0				
Records added from the oversample list	0				
Denominator	411				
Numerator events by administrative data		369	390	386	394
Number of numerator events by medical records		0	0	0	0
Reported rate		89.78%	94.89%	93.92%	95.86%
Lower 95% confidence interval		86.73%	92.64%	91.48%	93.82%
Upper 95% confidence interval		92.83%	97.14%	96.35%	97.91%

Spec Proj: None)

Hepatitis B	VZV	Pneumo-coccal Conjugate	Hepatitis A	Rotavirus	Influenza	Combination 2	Combination 3
836	820	778	502	543	704	770	749
95.65%	93.82%	89.02%	57.44%	62.13%	80.55%	88.10%	85.70%
409	403	381	241	271	346	380	370
94.68%	93.29%	88.19%	55.79%	62.73%	80.09%	87.96%	85.65%
389	384	365	230	257	330	362	354
2	0	0	0	0	2	2	2
95.13%	93.43%	88.81%	55.96%	62.53%	80.78%	88.56%	86.62%
92.93%	90.91%	85.64%	51.04%	57.73%	76.85%	85.37%	83.20%
97.34%	95.95%	91.98%	60.88%	67.33%	84.71%	91.76%	90.03%

Combination 4	Combination 5	Combination 6	Combination 7	Combination 8	Combination 9	Combination 10
479	523	657	338	439	468	314
54.81%	59.84%	75.17%	38.67%	50.23%	53.55%	35.93%
231	261	327	165	213	234	153
53.47%	60.42%	75.69%	38.19%	49.31%	54.17%	35.42%
221	248	313	157	203	222	145
1	0	3	0	3	2	2
54.01%	60.34%	76.89%	38.20%	50.12%	54.50%	35.77%
49.07%	55.49%	72.69%	33.38%	45.17%	49.57%	31.01%
58.95%	65.19%	81.08%	43.02%	55.08%	59.44%	40.52%

Immunizations for Adolescents (IMA)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid,				
Data Element	General Measure Data	Meningococcal	Tdap/Td	Combination 1
Measurement year	2009			
Data collection methodology (administrative or hybrid)	H			
Eligible population	538			
Number of numerator events by admin data in eligible population (before exclusions)		253	385	236
Current year's administrative rate (before exclusions)		47.03%	71.56%	43.87%
Minimum required sample size (MRSS) or other sample Size	411			
Oversampling rate	.05			
Final sample size	432			
Number of numerator events by admin data in FSS		198	314	187
Administrative rate on FSS		45.83%	72.69%	43.29%
Number of original records excluded because of valid data errors	0			
Number of administrative data records excluded	0			
Number of medical data records excluded	0			
Number of employee/dependent medical records excluded	0			
Records added from the oversample list	0			
Denominator	411			
Numerator events by administrative data		187	297	177
Number of numerator events by medical records		1	1	2
Reported rate		45.74%	72.51%	43.55%
Lower 95% confidence interval		40.80%	68.07%	38.64%
Upper 95% confidence interval		50.68%	76.94%	48.47%

Lead Screening in Children (LSC)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Lead Screening in Children	
Data Elements which do not apply to the selected data collection methodology will not appear	General Measure Data
Measurement year	2009
Data collection methodology (administrative or hybrid)	A
Eligible population	874
Number of numerator events by admin data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data	NR
Number of administrative data records excluded	NR
Number of medical data records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample	NR
Denominator	NR
Numerator events by administrative data	786
Numerator events by medical	NR
Reported rate	89.93%
Lower 95% confidence interval	87.88%
Upper 95% confidence interval	91.98%

Breast Cancer Screening (BCS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**General Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	693
Numerator events by administrative data	536
Reported rate	77.34%
Lower 95% confidence interval	74.16%
Upper 95% confidence interval	80.53%

Cervical Cancer Screening (CCS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative or hybrid)	A
Eligible population	2788
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data	NR
Number of administrative data records excluded	NR
Number of medical data records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample	NR
Denominator	NR
Numerator events by administrative data	2302
Numerator events by medical	NR
Reported rate	82.57%
Lower 95% confidence interval	81.14%
Upper 95% confidence interval	83.99%

Chlamydia Screening in Women (CHL)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid,				
Data Element	**General Measure Data**	**16-20 years**	**21-24 years**	**Total**
Measurement year	2009			
Data collection methodology (administrative)	A			
Eligible population		537	546	1,083
Numerator events by administrative data		390	418	808
Reported rate		72.63%	76.56%	74.61%
Lower 95% confidence interval		68.76%	72.91%	71.97%
Upper 95% confidence interval		76.49%	80.20%	77.25%

Appropriate Testing for Children with Pharyngitis (CWP)	
Kaiser Foundation Health Plan, Inc. -	
Data Element	Measure Data
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	393
Numerator events by administrative data	352
Reported rate	89.57%
Lower 95% confidence interval	86.42%
Upper 95% confidence interval	92.72%

Appropriate Treatment for Children With URI (URI)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	Measure Data
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	1651
Numerator events by administrative data	38
Reported rate	97.70%
Lower 95% confidence interval	96.94%
Upper 95% confidence interval	98.45%

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	Measure Data
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	166
Total numerator events by administrative data	146
Reported rate	12.05%
Lower 95% confidence interval	6.79%
Upper 95% confidence interval	17.30%

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	16
Numerator events by administrative data	6
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Pharmacotherapy Management of COPD Exacerbation (PCE)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Pharmacotherapy Management of COPD Exacerbation			
Data Elements	Measure Data	Systemic corticosteroid	Bronchodilator
Measurement year	2009		
Data collection methodology (administrative)	A		
Eligible population	5		
Exclusions based on direct transfers to another facility*	NR		
Exclusions based on readmissions*	NR		
Numerator events by administrative data		3	5
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA
* Reporting this additional data element is optional in IDSS.			

Use of Appropriate Medications for People With Asthma (ASM)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid,				
Data Element	**General Measure Data**	**5-11 years**	**12-50 years**	**Total**
Measurement year	2009			
Data collection methodology (administrative)	A			
Eligible population		164	182	346
Numerator events by administrative data		162	172	334
Reported rate		98.78%	94.51%	96.53%
Lower 95% confidence interval		96.80%	90.92%	94.46%
Upper 95% confidence interval		100.00%	98.09%	98.60%

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**LDL-C Screening**	**LDL-C level <100 mg/dL**
Measurement year	2009		
Data collection methodology (administrative or hybrid)	A		
Eligible population	25		
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR
Current year's administrative rate (before exclusions)		NR	NR
Minimum required sample size (MRSS) or other sample size	NR		
Oversampling rate	NR		
Final sample size (FSS)	NR		
Number of numerator events by administrative data in FSS		NR	NR
Administrative rate on FSS		NR	NR
Number of original sample records excluded because of valid data	NR		
Number of employee/dependent medical records excluded	NR		
Records added from the oversample	NR		
Denominator	NR		
Numerator events by administrative data		21	10
Numerator events by medical		NR	NR
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Controlling High Blood Pressure (CBP)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	General Measure Data
Measurement year	2009
Data collection methodology (hybrid)	H
Eligible population	398
Number of numerator events by administrative data in eligible population (before exclusions)	0
Current year's administrative rate (before exclusions)	0.00%
Minimum required sample size (MRSS) or other sample size	398
Oversampling rate	0
Final sample size (FSS)	398
Number of numerator events by administrative data in FSS	0
Administrative rate on FSS	0.00%
Number of original sample records excluded because of valid data errors	0
Number of records excluded because of false positive diagnoses	0
Number of administrative data records excluded	0
Number of medical data records excluded	1
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	397
Numerator events by administrative data	0
Numerator events by medical records	289
Reported rate	72.80%
Lower 95% confidence interval	68.29%
Upper 95% confidence interval	77.30%

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	3
Numerator events by administrative data	2
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Comprehensive Diabetes Care (CDC)										
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)										
Data Element	**HbA1c Testing**	**HbA1c Poor Control (>9.0%)**	**HbA1c Control (<8.0%)**	**HbA1c Control (<7.0%) for a Selected Population**	**Eye Exam**	**LDL-C Screening**	**LDL-C Level <100 mg/dL**	**Medical Attention for Nephropathy**	**Blood Pressure Controlled <130/80 mm Hg**	**Blood Pressure Controlled <140/90 mm Hg**
Measurement year	2009	2009	2009	2009	2009	2009	2009	2009	2009	2009
Data collection methodology (administrative or hybrid)	H	H	H	H	H	H	H	H	H	H
Eligible population	469	469	469	426	469	469	469	469	469	469
Number of numerator events by administrative data in eligible population (before exclusions)	408	237	176	89	287	378	187	368	240	355
Current year's administrative rate (before exclusions)	86.99%	50.53%	37.53%	20.89%	61.19%	80.60%	39.87%	78.46%	51.17%	75.69%
Minimum required sample size (MRSS) or other sample size	469	469	469	426	469	469	469	469	469	469
Oversampling rate	0	0	0	0	0	0	0	0	0	0
Final sample size (FSS)	469	469	469	426	469	469	469	469	469	469
Number of numerator events by administrative data in FSS	408	237	176	89	287	378	187	368	240	355
Administrative rate on FSS	86.99%	50.53%	37.53%	20.89%	61.19%	80.60%	39.87%	78.46%	51.17%	75.69%
Number of original sample records excluded because of valid data errors	0	0	0	0	0	0	0	0	0	0

Number of administrative data records excluded	0	0	0	0	0	0	0	0	0	0
Number of medical data records excluded	24	24	24	24	24	24	24	24	24	24
Number of administrative HbA1C <7 required exclusions				43						
Number of hybrid HbA1C <7 required exclusions				0						
Number of employee/dependent medical records excluded	0	0	0	0	0	0	0	0	0	0
Records added from the oversample list	0	0	0	0	0	0	0	0	0	0
Denominator	445	445	445	402	445	445	445	445	445	445
Numerator events by administrative data	391	230	160	74	283	375	187	368	228	336
Numerator events by medical records	2	0	0	0	55	4	2	8	3	5
Reported rate	88.31%	51.69%	35.96%	18.41%	75.96%	85.17%	42.47%	84.49%	51.91%	76.63%
Lower 95% confidence interval	85.22%	46.93%	31.38%	14.50%	71.87%	81.75%	37.77%	81.02%	47.16%	72.58%
Upper 95% confidence interval	91.41%	56.44%	40.53%	22.32%	80.04%	88.58%	47.18%	87.97%	56.66%	80.67%

Disease Modifying Anti-Rheumatic Drug therapy in Rheumatoid Arthritis (ART)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	11
Numerator events by administrative data	10
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Use of Imaging Studies for Low Back Pain (LBP)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	Measure Data
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	171
Numerator events by administrative data	36
Reported rate	78.95%
Lower 95% confidence Interval	72.54%
Upper 95% confidence Interval	85.35%

Antidepressant Medication Management (AMM)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	General Measure Data	Effective Acute Phase Treatment	Effective Continuation Phase Treatment
Measurement year	2009		
Data collection methodology (administrative)	A		
Eligible population	94		
Numerator events by administrative data		38	21
Reported rate		40.43%	22.34%
Lower 95% confidence interval		29.97%	13.39%
Upper 95% confidence interval		50.88%	31.29%

Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**Initiation Phase**	**Continuation and Maintenance Phase**
Measurement year	2009		
Data collection methodology (administrative)	A		
Eligible population		47	9
Numerator events by administrative data		32	7
Reported rate		68.09%	NA
Lower 95% confidence interval		53.69%	NA
Upper 95% confidence interval		82.48%	NA

Follow-Up After Hospitalization for Mental Illness (FUH)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**30-day follow-up**	**7-day follow-up**
Measurement year	2009		
Data collection methodology (administrative)	A		
Eligible population	66		
Numerator events by administrative data		54	40
Reported rate		81.82%	60.61%
Lower 95% confidence interval		71.76%	48.06%
Upper 95% confidence interval		91.88%	73.15%

Annual Monitoring for Patients on Persistent Medications (MPM)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)						
Data Element	**General Measure Data**	**ACE Inhibitors or ARBs**	**Digoxin**	**Diuretics**	**Anti-convulsants**	**Total**
Measurement year	2009					
Data collection methodology (administrative)	A					
Eligible population		301	8	173	23	505
Numerator events by administrative data		260	7	145	16	428
Reported rate		86.38%	NA	83.82%	NA	84.75%
Lower 95% confidence interval		82.34%	NA	78.04%	NA	81.52%
Upper 95% confidence interval		90.42%	NA	89.59%	NA	87.99%

Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**20-44 years**	**45-64 years**	**65+ years**	**Total**
Measurement year	2009				
Data collection methodology (administrative)	A				
Eligible population		3762	1180	0	4,942
Numerator events by administrative data		3223	1028	0	4,251
Reported rate		85.67%	87.12%	NA	86.02%
Lower 95% confidence interval		84.54%	85.16%	NA	85.04%
Upper 95% confidence interval		86.81%	89.07%	NA	86.99%

Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**12-24 months**	**25 months - 6 years**	**7-11 years**	**12-19 years**
Measurement year	2009				
Data collection methodology (administrative)	A				
Eligible population		949	3935	2719	3393
Numerator events by administrative data		942	3629	2540	3138
Reported rate		99.26%	92.22%	93.42%	92.48%
Lower 95% confidence interval		98.67%	91.37%	92.47%	91.58%
Upper 95% confidence interval		99.86%	93.07%	94.37%	93.39%

Annual Dental Visit (ADV)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Data Element	**Measure Data**	**2-3 Years**	**4-6 Years**	**7-10 Years**	**11-14 Years**	**15-18 Years**	**19-21 Years**	**Total**
Measurement year	NR							
Data collection methodology (administrative)	NR							
Eligible population		NR	NR	NR	NR	NR	NR	NR
Numerator events by administrative data		NR	NR	NR	NR	NR	NR	NR
Reported rate		NR	NR	NR	NR	NR	NR	NR
Lower 95% confidence interval		NR	NR	NR	NR	NR	NR	NR
Upper 95% confidence interval		NR	NR	NR	NR	NR	NR	NR

Initiation and Engagement of AOD Dependence Treatment (IET)							
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)							
Data Elements	General Measure Data	13-17 years		18+ years		Total	
		Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
Measurement year	2009						
Data collection methodology (administrative)	A						
Eligible population		38		374		412	
Numerator events by administrative data		18	7	200	89	218	96
Reported rate		47.37%	18.42%	53.48%	23.80%	52.91%	23.30%
Lower 95% confidence interval		30.18%	4.78%	48.29%	19.35%	47.97%	19.10%
Upper 95% confidence interval		64.56%	32.06%	58.66%	28.25%	57.85%	27.50%

Prenatal and Postpartum Care (PPC)		
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124,		
Data Element	Timeliness of Prenatal Care	Postpartum Care
Measurement year	2008	2008
Data collection methodology (administrative or hybrid)	H	H
Eligible population	635	635
Number of numerator events by administrative data in eligible population (before exclusions)	534	443
Current year's administrative rate (before exclusions)	84.09%	69.76%
Minimum required sample size (MRSS) or other sample size	411	411
Oversampling rate	.05	.05
Final sample size (FSS)	432	432
Number of numerator events by administrative data in FSS	366	306
Administrative rate on FSS	84.72%	70.83%
Number of original sample records excluded because of valid data	1	1
Number of employee/dependent medical records excluded	0	0
Records added from the oversample	1	1
Denominator	411	411
Numerator events by administrative data	349	292
Numerator events by medical	28	31
Reported rate	91.73%	78.59%
Lower 95% confidence interval	88.94%	74.50%
Upper 95% confidence interval	94.51%	82.68%

Call Answer Timeliness (CAT)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	199238
Numerator events by administrative data	187119
Reported rate	93.92%
Lower 95% confidence interval	93.81%
Upper 95% confidence interval	94.02%

Call Abandonment (CAB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative)	A
Eligible population	199238
Numerator events by administrative data	2002
Reported rate	1.00%
Lower 95% confidence interval	0.96%
Upper 95% confidence interval	1.05%

Frequency of Ongoing Prenatal Care (FPC)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)						
Data Element	**General Measure Data**	**<21 Percent**	**21-40 Percent**	**41-60 Percent**	**61-80 Percent**	**81+ Percent**
Measurement year	2008					
Data collection methodology (administrative or hybrid)	A					
Eligible population	635					
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR	NR	NR
Minimum required sample size (MRSS) or other sample size	NR					
Oversampling rate	NR					
Final sample size (FSS)	NR					
Number of numerator events by administrative data in FSS		NR	NR	NR	NR	NR
Administrative rate on FSS		NR	NR	NR	NR	NR
Number of original sample records excluded because of valid data	NR					
Number of employee/dependent medical records excluded	NR					
Records added from the oversample	NR					
Denominator	NR					
Numerator events by administrative data		38	36	49	113	396
Numerator events by medical		NR	NR	NR	NR	NR
Reported rate		5.98%	5.67%	7.72%	17.80%	62.36%
Lower 95% confidence interval		4.06%	3.79%	5.56%	14.74%	58.52%
Upper 95% confidence interval		7.91%	7.55%	9.87%	20.85%	66.21%

Well-Child Visits in the First 15 Months of Life (W15)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Data Element	**Measure Data**	**0 visits**	**1 visit**	**2 visits**	**3 visits**	**4 visits**	**5 visits**	**6 or more visits**
Measurement year	2009							
Data collection methodology (administrative or hybrid)	A							
Eligible population	759							
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Minimum required sample size (MRSS) or other sample size	NR							
Oversampling rate	NR							
Final sample size (FSS)	NR							
Number of numerator events by administrative data in FSS		NR	NR	NR	NR	NR	NR	NR
Administrative rate on FSS		NR	NR	NR	NR	NR	NR	NR
Number of original sample records excluded because of valid data	NR							
Number of employee/dependent medical records excluded	NR							
Records added from the oversample	NR							
Denominator	NR							
Numerator events by administrative data		3	4	12	19	38	100	583
Numerator events by medical		NR	NR	NR	NR	NR	NR	NR
Reported rate		0.40%	0.53%	1.58%	2.50%	5.01%	13.18%	76.81%
Lower 95% confidence interval		0.00%	0.00%	0.63%	1.33%	3.39%	10.70%	73.74%
Upper 95% confidence interval		0.91%	1.11%	2.53%	3.68%	6.62%	15.65%	79.88%

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative or hybrid)	A
Eligible population	3097
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	2186
Numerator events by medical records	NR
Reported rate	70.58%
Lower 95% confidence interval	68.96%
Upper 95% confidence interval	72.21%

Adolescent Well-Care Visits (AWC)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2009
Data collection methodology (administrative or hybrid)	A
Eligible population	4405
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample	NR
Denominator	NR
Numerator events by administrative data	1879
Numerator events by medical	NR
Reported rate	42.66%
Lower 95% confidence interval	41.18%
Upper 95% confidence interval	44.13%

Frequency of Selected Procedures (FSP)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid,				
Age	**Male**	**Female**	**Total**	
0-4			60,301	
0-9			106,759	
5-19			117,317	
10-19			70,859	
15-44		60,614		
20-44	18,235	43,601		
30-64	18,366			
45-64	8,477	10,468		
Procedure	**Age**	**Sex**	**Number of Procedures**	**Procedures / 1,000 Member Months**
Myringotomy	**0-4**	**Male & Female**	30	0.50
	5-19		11	0.09
Tonsillectomy	**0-9**	**Male & Female**	9	0.08
	10-19		9	0.13
Dilation & Curettage	**15-44**	**Female**	22	0.36
	45-64		4	0.38
Hysterectomy, Abdominal	**15-44**	**Female**	1	0.02
	45-64		1	0.10
Hysterectomy,Vaginal	**15-44**	**Female**	4	0.07
	45-64		2	0.19
Cholecystectomy,Open	**30-64**	**Male**	1	0.05
	15-44	**Female**	1	0.02
	45-64		3	0.29
Cholecystectomy,Closed (laparoscopic)	**30-64**	**Male**	6	0.33
	15-44	**Female**	33	0.54
	45-64		6	0.57
Back Surgery	**20-44**	**Male**	5	0.27
		Female	0	0.00
	45-64	**Male**	3	0.35
		Female	2	0.19
Mastectomy	**15-44**	**Female**	1	0.02
	45-64		0	0.00
Lumpectomy	**15-44**	**Female**	12	0.20
	45-64		2	0.19

Ambulatory Care: Total (AMBA)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	**Member Months**
<1	13,682
1-9	93,077
10-19	70,859
20-44	61,836
45-64	18,945
65-74	0
75-84	0
85+	0
Unknown	0
Total	258,399

Age	Outpatient Visits		ED Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	13141	960.46	676	49.41	121	8.84	15	1.10
1-9	33985	365.13	2321	24.94	136	1.46	13	0.14
10-19	21785	307.44	1323	18.67	162	2.29	89	1.26
20-44	35325	571.27	2334	37.75	811	13.12	358	5.79
45-64	12628	666.56	727	38.37	349	18.42	6	0.32
65-74	0	NA	0	NA	0	NA	0	NA
75-84	0	NA	0	NA	0	NA	0	NA
85+	0	NA	0	NA	0	NA	0	NA
Unknown	0		0		0		0	
Total	116,864	452.26	7,381	28.56	1,579	6.11	481	1.86

Ambulatory Care: Dual Eligibles (AMBB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	Member Months
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Age	Outpatient Visits		ED Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	NR	NR	NR	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR		NR		NR		NR	
Total	NR	NR	NR	NR	NR	NR	NR	NR

Ambulatory Care: Disabled (AMBC)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	Member Months
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Age	Outpatient Visits		ED Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	NR	NR	NR	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR		NR		NR		NR	
Total	NR	NR	NR	NR	NR	NR	NR	NR

Ambulatory Care: Other (AMBD)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	Member Months
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Age	Outpatient Visits		ED Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in	
	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	NR	NR	NR	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR		NR		NR		NR	
Total	NR	NR	NR	NR	NR	NR	NR	NR

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	**Member Months**
<1	13,682
1-9	93,077
10-19	70,859
20-44	61,836
45-64	18,945
65-74	0
75-84	0
85+	0
Unknown	0
Total	258,399

Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	79	5.77	391	28.58	4.95
1-9	98	1.05	277	2.98	2.83
10-19	240	3.39	634	8.95	2.64
20-44	959	15.51	2594	41.95	2.70
45-64	189	9.98	883	46.61	4.67
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	1,565	6.06	4,779	18.49	3.05

Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	73	5.34	317	23.17	4.34
1-9	77	0.83	212	2.28	2.75
10-19	45	0.64	189	2.67	4.20
20-44	150	2.43	623	10.08	4.15
45-64	124	6.55	513	27.08	4.14
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	469	1.82	1,854	7.17	3.95

Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	6	0.44	74	5.41	12.33
1-9	21	0.23	65	0.70	3.10
10-19	31	0.44	70	0.99	2.26
20-44	67	1.08	290	4.69	4.33
45-64	65	3.43	370	19.53	5.69
65-74	0	NA	0	NA	NA

75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	190	0.74	869	3.36	4.57
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	164	2.31	375	5.29	2.29
20-44	742	12.00	1681	27.18	2.27
45-64	0	0.00	0	0.00	NA
Unknown	0		0		NA
Total	906	5.97	2,056	13.56	2.27

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (IPUB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:	
Age	**Member Months**
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR

1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Disabled (IPUC)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR

1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Other (IPUD)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**

<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--Nonacute Care: Total (NONA)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Age	**Member Months**				
<1	13,682				
1-9	93,077				
10-19	70,859				
20-44	61,836				
45-64	18,945				
65-74	0				
75-84	0				
85+	0				
Unknown	0				
Total	258,399				
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Member Months**	**Average Length of Stay**
<1	0	0.00	0	0.00	NA
1-9	1	0.01	6	0.06	6.00
10-19	5	0.07	34	0.48	6.80
20-44	5	0.08	93	1.50	18.60
45-64	0	0.00	0	0.00	NA
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	11	0.04	133	0.51	12.09

Inpatient Utilization--Nonacute Care: Dual Eligibles (NONB)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Member Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Inpatient Utilization--Nonacute Care: Disabled (NONC)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Member Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Inpatient Utilization--Nonacute Care: Other (NOND)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Member Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Identification of Alcohol and Other Drug Services: Total (IADA)									
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)									
Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	67453	63140	130,593	67453	63140	130,593	67453	63140	130,593
13-17	17899	18382	36,281	17899	18382	36,281	17899	18382	36,281
18-24	8854	19250	28,104	8854	19250	28,104	8854	19250	28,104
25-34	7360	19502	26,862	7360	19502	26,862	7360	19502	26,862
35-64	14982	21577	36,559	14982	21577	36,559	14982	21577	36,559
65+	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0

Total	116,548	141,851	258,399	116,548	141,851	258,399	116,548	141,851	258,399
Age	Sex	Any Services		Inpatient		Intensive		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	M	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	F	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	Total	0	0.00%	0	0.00%	0	0.00%	0	0.00%
13-17	M	27	1.81%	6	0.40%	0	0.00%	23	1.54%
	F	26	1.70%	10	0.65%	0	0.00%	19	1.24%
	Total	53	1.75%	16	0.53%	0	0.00%	42	1.39%
18-24	M	40	5.42%	11	1.49%	0	0.00%	35	4.74%
	F	44	2.74%	8	0.50%	0	0.00%	40	2.49%
	Total	84	3.59%	19	0.81%	0	0.00%	75	3.20%
25-34	M	47	7.66%	9	1.47%	0	0.00%	42	6.85%
	F	57	3.51%	6	0.37%	0	0.00%	55	3.38%
	Total	104	4.65%	15	0.67%	0	0.00%	97	4.33%
35-64	M	127	10.17%	28	2.24%	0	0.00%	115	9.21%
	F	80	4.45%	14	0.78%	0	0.00%	75	4.17%
	Total	207	6.79%	42	1.38%	0	0.00%	190	6.24%
65+	M	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Unknown	M	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA

Total	**M**	241	2.48%	54	0.56%	0	0.00%	215	2.21%
	F	207	1.75%	38	0.32%	0	0.00%	189	1.60%
	Total	448	2.08%	92	0.43%	0	0.00%	404	1.88%

Member Months (Outpatient/ED)		
Male	**Female**	**Total**
67453	63140	130,593
17899	18382	36,281
8854	19250	28,104
7360	19502	26,862
14982	21577	36,559
0	0	0
0	0	0

116,548	141,851	258,399

Identification of Alcohol and Other Drug Services: Dual Eligibles (IADB)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive Outpatient/Partial Hospitalization)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	NR	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
65+	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR	NR

Unknown	**F**	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR

Member Months (Outpatient/ED)		
Male	**Female**	**Total**
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR

Identification of Alcohol and Other Drug Services: Disabled (IADC)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive Outpatient/Partial Hospitalization)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	NR	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
65+	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR	NR

Unknown	**F**	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR

Member Months (Outpatient/ED)		
Male	**Female**	**Total**
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR

Identification of Alcohol and Other Drug Services: Other (IADD)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive Outpatient/Partial Hospitalization)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	NR	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
65+	M	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR	NR

Unknown	**F**	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR	NR

Member Months (Outpatient/ED)		
Male	**Female**	**Total**
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR
NR	NR	NR

Mental Health Utilization: Total (MPTA)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive Outpatient/Partial Hospitalization)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	67453	63140	130,593	67453	63140	130,593	67453	63140	130,593
13-17	17899	18382	36,281	17899	18382	36,281	17899	18382	36,281
18-64	31196	60329	91,525	31196	60329	91,525	31196	60329	91,525
65+	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0
Total	116,548	141,851	258,399	116,548	141,851	258,399	116,548	141,851	258,399

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	M	214	3.81%	4	0.07%	0	0.00%	211	3.75%
	F	96	1.82%	1	0.02%	0	0.00%	96	1.82%
	Total	310	2.85%	5	0.05%	0	0.00%	307	2.82%
13-17	M	113	7.58%	15	1.01%	1	0.07%	108	7.24%
	F	126	8.23%	21	1.37%	0	0.00%	122	7.96%
	Total	239	7.90%	36	1.19%	1	0.03%	230	7.61%
18-64	M	259	9.96%	38	1.46%	2	0.08%	244	9.39%
	F	549	10.92%	42	0.84%	1	0.02%	540	10.74%
	Total	808	10.59%	80	1.05%	3	0.04%	784	10.28%
65+	M	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Unknown	M	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Total	M	586	6.03%	57	0.59%	3	0.03%	563	5.80%
	F	771	6.52%	64	0.54%	1	0.01%	758	6.41%
	Total	1,357	6.30%	121	0.56%	4	0.02%	1,321	6.13%

Member Months (Outpatient/ED)		
Male	**Female**	**Total**
67453	63140	130,593
17899	18382	36,281
31196	60329	91,525
0	0	0
0	0	0
116,548	141,851	258,399

Mental Health Utilization: Dual Eligibles (MPTB)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Age	Member Months (Any)			Member Months (Inpatient)			Member Months (In	
	Male	Female	Total	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient		Intensive		Outpati
		Number	Percent	Number	Percent	Number	Percent	Number
0-12	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-64	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65+	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

tensive	Member Months (Outpatient/ED)		
Total	Male	Female	Total
NR	NR	NR	NR
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Mental Health Utilization: Disabled (MPTC)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Age	**Member Months (Any)**			**Member Months (Inpatient)**			**Member Months (In Outpatient/Partial Hosp**	
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
0-12	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR

Age	**Sex**	**Any Services**		**Inpatient**		**Intensive Outpatient/Partial Hospitalization**		**Outpati**
		Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**
0-12	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
13-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

tensive italization)	Member Months (Outpatient/ED)		
Total	Male	Female	Total
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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Mental Health Utilization: Other (MPTD)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Age	Member Months (Any)			Member Months (Inpatient)			Member Months (In Outpatient/Partial Hosp	
	Male	Female	Total	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpati
		Number	Percent	Number	Percent	Number	Percent	Number
0-12	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-64	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65+	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

tensive italization)	Member Months (Outpatient/ED)		
Total	Male	Female	Total
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

ient/ED
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Antibiotic Utilization: Total (ABXA)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Pharmacy Benefit Member Months

Age	Male	Female	Total
0-9	55114	51645	106,759
10-17	30238	29877	60,115
18-34	16214	38752	54,966
35-49	9416	14972	24,388
50-64	5566	6605	12,171
65-74	0	0	0
75-84	0	0	0
85+	0	0	0
Unknown	0	0	0
Total	116,548	141,851	258,399

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	5040	1.10	47497	9.42	1651	0.36	32.76%
	F	4713	1.10	45682	9.69	1368	0.32	29.03%
	Total	9,753	1.10	93,179	9.55	3,019	0.34	30.95%
10-17	M	1303	0.52	14463	11.10	304	0.12	23.33%
	F	1658	0.67	17876	10.78	358	0.14	21.59%
	Total	2,961	0.59	32,339	10.92	662	0.13	22.36%
18-34	M	840	0.62	8975	10.68	213	0.16	25.36%
	F	3875	1.20	35085	9.05	946	0.29	24.41%
	Total	4,715	1.03	44,060	9.34	1,159	0.25	24.58%
35-49	M	662	0.84	6970	10.53	240	0.31	36.25%
	F	1572	1.26	14787	9.41	423	0.34	26.91%
	Total	2,234	1.10	21,757	9.74	663	0.33	29.68%
50-64	M	452	0.97	4694	10.38	146	0.31	32.30%
	F	678	1.23	6489	9.57	220	0.40	32.45%

	Total	1,130	1.11	11,183	9.90	366	0.36	32.39%
65-74	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
75-84	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
85+	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
Unknown	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
Total	M	8,297	0.85	82,599	9.96	2,554	0.26	30.78%
	F	12,496	1.06	119,919	9.60	3,315	0.28	26.53%
	Total	20,793	0.97	202,518	9.74	5,869	0.27	28.23%

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalo-sporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalo-sporins 2nd-4th Generation	Total Azithromycin and Clarithro-mycin Scrips	Average Scrips PMPY for Azithromycins and Clarithro-mycins	Total Amoxicillin / Clavulanate Scrips	Average Scrips PMPY for Amoxicillin / Clavulanates
0-9	M	0	0.00	297	0.06	652	0.14	646	0.14
	F	0	0.00	252	0.06	512	0.12	561	0.13
	Total	0	0.00	549	0.06	1,164	0.13	1,207	0.14
10-17	M	13	0.01	26	0.01	88	0.03	131	0.05
	F	15	0.01	34	0.01	127	0.05	137	0.06
	Total	28	0.01	60	0.01	215	0.04	268	0.05
18-34	M	31	0.02	6	0.00	48	0.04	79	0.06
	F	299	0.09	31	0.01	275	0.09	248	0.08
	Total	330	0.07	37	0.01	323	0.07	327	0.07
35-49	M	71	0.09	8	0.01	34	0.04	75	0.10
	F	121	0.10	17	0.01	85	0.07	132	0.11
	Total	192	0.09	25	0.01	119	0.06	207	0.10

50-64	**M**	64	0.14	5	0.01	19	0.04	32	0.07
	F	85	0.15	8	0.01	44	0.08	46	0.08
	Total	149	0.15	13	0.01	63	0.06	78	0.08
65-74	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
75-84	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
85+	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Unknown	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Total	**M**	179	0.02	342	0.04	841	0.09	963	0.10
	F	520	0.04	342	0.03	1,043	0.09	1,124	0.10
	Total	699	0.03	684	0.03	1,884	0.09	2,087	0.10

All Other Antibiotics Utilization

0	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Amino-glycoside Scrips**	**Average Scrips PMPY for Amino-glycosides**	**Total 1st Generation Cephalo-sporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalo-**	**Total Lincosamide Scrips**	**Average Scrips PMPY for Lincosamides**
0-9	**M**	337	0.07	0	0.00	423	0.09	0	0.00
	F	432	0.10	0	0.00	470	0.11	0	0.00
	Total	769	0.09	0	0.00	893	0.10	0	0.00
10-17	**M**	120	0.05	0	0.00	159	0.06	0	0.00
	F	193	0.08	0	0.00	237	0.10	0	0.00
	Total	313	0.06	0	0.00	396	0.08	0	0.00
18-34	**M**	120	0.09	0	0.00	96	0.07	0	0.00
	F	456	0.14	0	0.00	423	0.13	0	0.00
	Total	576	0.13	0	0.00	519	0.11	0	0.00
35-49	**M**	104	0.13	0	0.00	85	0.11	0	0.00
	F	208	0.17	0	0.00	170	0.14	0	0.00

	Total	312	0.15	0	0.00	255	0.13	0	0.00
50-64	**M**	77	0.17	0	0.00	65	0.14	0	0.00
	F	89	0.16	0	0.00	61	0.11	0	0.00
	Total	166	0.16	0	0.00	126	0.12	0	0.00
65-74	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
75-84	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
85+	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Unknown	**M**	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Total	**M**	758	0.08	0	0.00	828	0.09	0	0.00
	F	1,378	0.12	0	0.00	1,361	0.12	0	0.00
	Total	2,136	0.10	0	0.00	2,189	0.10	0	0.00

Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0	0.00	47	0.01	9	0.00
0	0.00	37	0.01	6	0.00
0	0.00	84	0.01	15	0.00
0	0.00	43	0.02	3	0.00
0	0.00	45	0.02	0	0.00
0	0.00	88	0.02	3	0.00
0	0.00	48	0.04	1	0.00
0	0.00	91	0.03	2	0.00
0	0.00	139	0.03	3	0.00
0	0.00	46	0.06	6	0.01
0	0.00	65	0.05	3	0.00
0	0.00	111	0.05	9	0.00

0	0.00	21	0.05	5	0.01
0	0.00	35	0.06	2	0.00
0	0.00	56	0.06	7	0.01
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	NA	0	NA	0	NA
0	0.00	205	0.02	24	0.00
0	0.00	273	0.02	13	0.00
0	0.00	478	0.02	37	0.00

Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
87	0.02	2527	0.55	2	0.00	13	0.00
76	0.02	2317	0.54	0	0.00	50	0.01
163	0.02	4,844	0.54	2	0.00	63	0.01
33	0.01	517	0.21	167	0.07	3	0.00
34	0.01	632	0.25	168	0.07	36	0.01
67	0.01	1,149	0.23	335	0.07	39	0.01
28	0.02	238	0.18	137	0.10	8	0.01
73	0.02	881	0.27	623	0.19	473	0.15
101	0.02	1,119	0.24	760	0.17	481	0.11
6	0.01	124	0.16	84	0.11	19	0.02
21	0.02	357	0.29	243	0.19	150	0.12

27	0.01	481	0.24	327	0.16	169	0.08
6	0.01	85	0.18	68	0.15	5	0.01
13	0.02	134	0.24	117	0.21	44	0.08
19	0.02	219	0.22	185	0.18	49	0.05
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
0	NA	0	NA	0	NA	0	NA
160	0.02	3,491	0.36	458	0.05	48	0.00
217	0.02	4,321	0.37	1,151	0.10	753	0.06
377	0.02	7,812	0.36	1,609	0.07	801	0.04

Antibiotic Utilization: Dual Eligibles (ABXB)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

on

Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

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NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Antibiotic Utilization: Disabled (ABXC)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

on

Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Antibiotic Utilization: Other (ABXD)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

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Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR

Outpatient Drug Utilization: Total (ORXA)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Pharmacy Benefit Member Months	
Age	**Member Months**
0-9	106759
10-17	60115
18-34	54966
35-49	24388
50-64	12171
65-74	0
75-84	0
85+	0
Unknown	0
Total	258,399

Age	Total Cost of Prescriptions	Avg. Cost of Prescriptions/ Per Member	Total Number of Prescriptions	Avg. Num. of Prescriptions/ Per Member
0-9	1172269.44	$10.98	52132	5.86
10-17	668250.80	$11.12	18595	3.71
18-34	1236605.61	$22.50	37643	8.22
35-49	1385667.63	$56.82	32240	15.86
50-64	1266368.39	$104.05	31018	30.58
65-74	0	NA	0	NA
75-84	0	NA	0	NA
85+	0	NA	0	NA
Unknown	0		0	
Total	$5,729,161.87	$22.17	171,628	7.97

Outpatient Drug Utilization: Dual Eligibles (ORXB)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Pharmacy Benefit Member Months				
Age	Member Months			
0-9	NR			
10-17	NR			
18-34	NR			
35-49	NR			
50-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Total Cost of Prescriptions	Avg. Cost of Prescriptions/ Per Member	Total Number of Prescriptions	Avg. Num. of Prescriptions/ Per Member
0-9	NR	NR	NR	NR
10-17	NR	NR	NR	NR
18-34	NR	NR	NR	NR
35-49	NR	NR	NR	NR
50-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Outpatient Drug Utilization: Disabled (ORXC)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Pharmacy Benefit Member Months				
Age	Member Months			
0-9	NR			
10-17	NR			
18-34	NR			
35-49	NR			
50-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Total Cost of Prescriptions	Avg. Cost of Prescriptions/ Per Member	Total Number of Prescriptions	Avg. Num. of Prescriptions/ Per Member
0-9	NR	NR	NR	NR
10-17	NR	NR	NR	NR
18-34	NR	NR	NR	NR
35-49	NR	NR	NR	NR
50-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Outpatient Drug Utilization: Other (ORXD)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Pharmacy Benefit Member Months				
Age	Member Months			
0-9	NR			
10-17	NR			
18-34	NR			
35-49	NR			
50-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Total Cost of Prescriptions	Avg. Cost of Prescriptions/ Per Member	Total Number of Prescriptions	Avg. Num. of Prescriptions/ Per Member
0-9	NR	NR	NR	NR
10-17	NR	NR	NR	NR
18-34	NR	NR	NR	NR
35-49	NR	NR	NR	NR
50-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Relative Resource Use for People With Diabetes (RDI)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Eligible Population

Category	Eligible Population
Total	466
Exclusions (required)	3
Type 1 with Comorbidity	8
Type 2 with Comorbidity	257
Type 1 without Comorbidity	23
Type 2 without Comorbidity	178

Medical Benefit Member Months

Age	Member Months (Diabetes Type 1 with Comorbidity)			Member Months (Diabetes Type 1 without Comorbidity)			Member Months (Diabetes Type 2 with Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44*	36	60	96	118	156	274	476	741	1,217
45-54	0	0	0	0	0	0	466	428	894
55-64	0	0	0	0	0	0	323	626	949
65-75	0	0	0	0	0	0	0	0	0
Total	36	60	96	118	156	274	1,265	1,795	3,060

*** Include any Member Months that occur at age 17 in the 18-44 category.**

Pharmacy Benefit Member Months

Age	Member Months (Diabetes Type 1 with Comorbidity)			Member Months (Diabetes Type 1 without Comorbidity)			Member Months (Diabetes Type 2 with Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44	36	60	96	118	156	274	463	741	1,204
45-54	0	0	0	0	0	0	466	428	894
55-64	0	0	0	0	0	0	323	626	949
65-75	0	0	0	0	0	0	0	0	0
Total	36	60	96	118	156	274	1,252	1,795	3,047

Diabetes Type 1 with Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender	Total Service Frequency by Service Category, Age, and

Age	Sex	Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
18-44	M	0	304	3733	0	827	8181	0	5
	F	20035	884	3796	48	1938	14626	4	3
	Total	$20,035.00	$1,188.00	$7,529.00	$48.00	$2,765.00	$22,807.00	4	8
45-54	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
55-64	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	M	$0.00	$304.00	$3,733.00	$0.00	$827.00	$8,181.00	0	5
	F	$20,035.00	$884.00	$3,796.00	$48.00	$1,938.00	$14,626.00	4	3
	Total	$20,035.00	$1,188.00	$7,529.00	$48.00	$2,765.00	$22,807.00	4	8

Diabetes Type 1 without Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
18-44	M	61971	3099	2824	0	704	20769	7	11
	F	27251	2267	6118	493	1749	50856	5	12
	Total	$89,222.00	$5,366.00	$8,942.00	$493.00	$2,453.00	$71,625.00	12	23
45-54	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
55-64	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0

	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$61,971.00	$3,099.00	$2,824.00	$0.00	$704.00	$20,769.00	7	11
	F	$27,251.00	$2,267.00	$6,118.00	$493.00	$1,749.00	$50,856.00	5	12
	Total	$89,222.00	$5,366.00	$8,942.00	$493.00	$2,453.00	$71,625.00	12	23
Diabetes Type 2 with Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	**Surgery and Procedure -**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	88603	4071	25288	2460	13720	102132	10	38
	F	167902	7918	46399	2812	7414	115670	18	61
	Total	$256,505.0	$11,989.00	$71,687.00	$5,272.00	$21,134.00	$217,802.0	28	99
45-54	**M**	113117	7580	25576	9399	7294	106180	9	43
	F	115746	5217	29176	10588	5857	97384	7	35
	Total	$228,863.0	$12,797.00	$54,752.00	$19,987.00	$13,151.00	$203,564.0	16	78
55-64	**M**	62812	3069	16963	2289	6234	68533	5	18
	F	254897	8586	32892	10194	7102	189575	16	23
	Total	$317,709.0	$11,655.00	$49,855.00	$12,483.00	$13,336.00	$258,108.0	21	41
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$264,532.0	$14,720.00	$67,827.00	$14,148.00	$27,248.00	$276,845.0	24	99
	F	$538,545.0	$21,721.00	$108,467.0	$23,594.00	$20,373.00	$402,629.0	41	119
	Total	$803,077.0	$36,441.00	$176,294.0	$37,742.00	$47,621.00	$679,474.0	65	218
Diabetes Type 2 without Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	**Surgery and Procedure -**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	51845	2222	10909	3898	250	30058	5	10
	F	212501	12193	43222	6905	11508	71827	37	51
	Total	$264,346.0	$14,415.00	$54,131.00	$10,803.00	$11,758.00	$101,885.0	42	61

45-54	M	14288	919	6432	0	2536	27232	1	3
	F	13140	299	5138	1045	2208	23442	1	6
	Total	$27,428.00	$1,218.00	$11,570.00	$1,045.00	$4,744.00	$50,674.00	2	9
55-64	M	24016	1703	2564	3025	0	5545	3	6
	F	28817	630	8189	110	2179	26966	5	8
	Total	$52,833.00	$2,333.00	$10,753.00	$3,135.00	$2,179.00	$32,511.00	8	14
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	M	$90,149.00	$4,844.00	$19,905.00	$6,923.00	$2,786.00	$62,835.00	9	19
	F	$254,458.0	$13,122.00	$56,549.00	$8,060.00	$15,895.00	$122,235.0	43	65
	Total	$344,607.0	$17,966.00	$76,454.00	$14,983.00	$18,681.00	$185,070.0	52	84

Diabetes Totals

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility - PMPM	E & M - Inpatient - PMPM	E & M - Outpatient - PMPM	Surgery and Procedure - Inpatient - PMPM	Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years	ED Visits/1,000 Member Years
18-44	M	$198.84	$9.52	$42.00	$6.25	$15.23	$160.34	259.33	754.42
	F	$212.99	$11.58	$49.57	$5.11	$11.26	$127.13	382.47	758.96
	Total	$208.23	$10.89	$47.02	$5.49	$12.59	$138.27	341.04	757.44
45-54	M	$203.85	$13.60	$51.21	$15.04	$15.73	$213.46	192.00	883.20
	F	$201.07	$8.61	$53.53	$18.15	$12.58	$188.50	149.77	767.55
	Total	$202.44	$11.07	$52.39	$16.61	$14.14	$200.82	170.62	824.64
55-64	M	$201.46	$11.07	$45.31	$12.33	$14.46	$171.87	222.74	668.21
	F	$352.00	$11.43	$50.97	$12.78	$11.51	$268.66	312.66	461.54
	Total	$299.55	$11.31	$49.00	$12.63	$12.54	$234.94	281.33	533.55
65-75	M	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA
	Total	NA	NA	NA	NA	NA	NA	NA	NA
Total	M	$200.89	$11.07	$45.46	$10.16	$15.22	$178.86	231.44	775.31
	F	$243.21	$11.00	$50.63	$9.32	$11.56	$171.76	323.01	691.17

	Total	$227.34	$11.03	$48.69	$9.63	$12.94	$174.42	288.66	722.73

Member Months (Diabetes Type 2 without Comorbidity)		
Male	**Female**	**Total**
388	1051	1,439
159	213	372
108	180	288
0	0	0
655	1,444	2,099

Member Months (Diabetes Type 2 without Comorbidity)		
Male	**Female**	**Total**
388	1033	1,421
159	213	372
108	180	288
0	0	0
655	1,426	2,081

Relative Resource Use for People With Asthma (RAS)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Eligible Population

Category	Eligible Population
Total	345
Exclusions (required)	1
With Comorbidity	31
Without Comorbidity	314

Medical and Pharmacy Benefit Member Months

Age	Medical Benefit Member Months						Pharmacy Benefi		
	Member Months (Asthma with Comorbidity)			Member Months (Asthma without Comorbidity)			Member Months (Asthma with Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
5-17*	48	24	72	1668	1092	2,760	48	24	72
18-44	23	215	238	239	667	906	23	215	238
45-50	12	48	60	12	84	96	12	48	60
Total	83	287	370	1,919	1,843	3,762	83	287	370

*** Include any Member Months that occur at age 4 in the 5-17 age category.**

Asthma with Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
5-17	M	2863	462	4142	0	616	3310	1	8
	F	0	0	398	0	0	553	0	4
	Total	$2,863.00	$462.00	$4,540.00	$0.00	$616.00	$3,863.00	1	12
18-44	M	0	289	2513	0	1033	2129	0	11
	F	15457	1355	15420	0	1722	35086	3	26
	Total	$15,457.00	$1,644.00	$17,933.00	$0.00	$2,755.00	$37,215.00	3	37
45-50	M	0	0	1010	0	0	11919	0	4
	F	10545	1244	3336	0	629	10687	1	2
	Total	$10,545.00	$1,244.00	$4,346.00	$0.00	$629.00	$22,606.00	1	6

Total	**M**	$2,863.00	$751.00	$7,665.00	$0.00	$1,649.00	$17,358.00	1	23
	F	$26,002.00	$2,599.00	$19,154.00	$0.00	$2,351.00	$46,326.00	4	32
	Total	$28,865.00	$3,350.00	$26,819.00	$0.00	$4,000.00	$63,684.00	5	55
Asthma without Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	**Surgery and Procedure -**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
5-17	**M**	3177	637	70324	0	4846	104587	1	38
	F	33911	2076	46861	0	2252	66598	6	27
	Total	$37,088.00	$2,713.00	$117,185.0	$0.00	$7,098.00	$171,185.0	7	65
18-44	**M**	0	0	6701	0	1239	33153	0	8
	F	28438	1284	25232	837	7811	52096	6	36
	Total	$28,438.00	$1,284.00	$31,933.00	$837.00	$9,050.00	$85,249.00	6	44
45-50	**M**	0	0	146	0	0	262	0	0
	F	0	0	5846	0	166	7730	0	2
	Total	$0.00	$0.00	$5,992.00	$0.00	$166.00	$7,992.00	0	2
Total	**M**	$3,177.00	$637.00	$77,171.00	$0.00	$6,085.00	$138,002.0	1	46
	F	$62,349.00	$3,360.00	$77,939.00	$837.00	$10,229.00	$126,424.0	12	65
	Total	$65,526.00	$3,997.00	$155,110.0	$837.00	$16,314.00	$264,426.0	13	111
Asthma Totals									
Age	**Sex**	**Total standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**	**Surgery and Procedure - Outpatient - PMPM**	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/1,000 Member Years**
5-17	**M**	$3.52	$0.64	$43.40	$0.00	$3.18	$62.88	13.99	321.68
	F	$30.39	$1.86	$42.35	$0.00	$2.02	$60.17	64.52	333.33
	Total	$14.11	$1.12	$42.98	$0.00	$2.72	$61.81	33.90	326.27
	M	$0.00	$1.10	$35.17	$0.00	$8.67	$134.66	0.00	870.23

18-44	**F**	$49.77	$2.99	$46.09	$0.95	$10.81	$98.85	122.45	843.54
	Total	$38.37	$2.56	$43.59	$0.73	$10.32	$107.05	94.41	849.65
45-50	**M**	$0.00	$0.00	$48.17	$0.00	$0.00	$507.54	0.00	2,000.00
	F	$79.89	$9.42	$69.56	$0.00	$6.02	$139.52	90.91	363.64
	Total	$67.60	$7.97	$66.27	$0.00	$5.10	$196.14	76.92	615.38
Total	**M**	$3.02	$0.69	$42.38	$0.00	$3.86	$77.60	11.99	413.59
	F	$41.48	$2.80	$45.58	$0.39	$5.91	$81.10	90.14	546.48
	Total	$22.84	$1.78	$44.03	$0.20	$4.92	$79.41	52.27	482.09

t Member Months

Member Months (Asthma without Comorbidity)		
Male	**Female**	**Total**
1668	1092	2,760
239	667	906
12	84	96
1,919	1,843	3,762

Relative Resource Use for People With Acute Lower Back Pain (RLB)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Eligible Population

Category	Eligible Population
Total	159
Exclusions (required)	1

Medical and Pharmacy Benefit Member Months

Age	Medical Benefit Member Months (Acute Low Back Pain)			Pharmacy Benefit Member Months (Acute Low Back Pain)		
	Male	Female	Total	Male	Female	Total
18-44*	48	242	290	48	242	290
45-50	6	22	28	6	22	28
Total	54	264	318	54	264	318

*** Include any Member Months that occur at age 17 in the 18-44 age category.**

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Servic Categor
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges
18-44	M	0	0	2232	0	84	1780	0
	F	0	0	10469	0	0	6477	0
	Total	$0.00	$0.00	$12,701.00	$0.00	$84.00	$8,257.00	0
45-50	M	0	0	329	0	0	133	0
	F	0	0	987	0	0	1020	0
	Total	$0.00	$0.00	$1,316.00	$0.00	$0.00	$1,153.00	0
Total	M	$0.00	$0.00	$2,561.00	$0.00	$84.00	$1,913.00	0
	F	$0.00	$0.00	$11,456.00	$0.00	$0.00	$7,497.00	0
	Total	$0.00	$0.00	$14,017.00	$0.00	$84.00	$9,410.00	0

Low Back Pain Totals

		Total Standard Cost by Service Category, Age, and Gender	Total Servic Categor

Age	Sex	Inpatient Facility - PMPM	E & M - Inpatient - PMPM	E & M - Outpatient - PMPM	Surgery and Procedure - Inpatient - PMPM	Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years
18-44	M	$0.00	$0.00	$46.50	$0.00	$1.75	$37.08	0.00
	F	$0.00	$0.00	$43.26	$0.00	$0.00	$26.76	0.00
	Total	$0.00	$0.00	$43.80	$0.00	$0.29	$28.47	0.00
45-50	M	$0.00	$0.00	$54.83	$0.00	$0.00	$22.17	0.00
	F	$0.00	$0.00	$44.86	$0.00	$0.00	$46.36	0.00
	Total	$0.00	$0.00	$47.00	$0.00	$0.00	$41.18	0.00
Total	M	$0.00	$0.00	$47.43	$0.00	$1.56	$35.43	0.00
	F	$0.00	$0.00	$43.39	$0.00	$0.00	$28.40	0.00
	Total	$0.00	$0.00	$44.08	$0.00	$0.26	$29.59	0.00

e Frequency by Service y, Age, and Gender

ED Visits	MRIs
1	2
5	4
6	6
0	0
1	2
1	2
1	2
6	6
7	8

e Frequency by Service y, Age, and Gender

ED Visits/1,000 Member Years	MRIs/1,000 Member Years
250.00	500.00
247.93	198.35
248.28	248.28
0.00	0.00
545.45	1,090.91
428.57	857.14
222.22	444.44
272.73	272.73
264.15	301.89

Relative Resource Use for People With Cardiovascular Conditions (RCA)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Eligible Population

Category	Eligible Population	Category	Eligible Population
Total	27		
Exclusions (required)	0		
CHF With Comorbidity	1	Angina With Comorbidity	2
CHF Without Comorbidity	0	Angina Without Comorbidity	1
AMI With Comorbidity	2	CAD With Comorbidity	18
AMI Without Comorbidity	1	CAD Without Comorbidity	2

Medical Benefit Member Months

Age	Member Months (CHF With Comorbidity)			Member Months (CHF Without Comorbidity)			Member Months (AMI With Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44	0	0	0	0	0	0	0	0	0
45-54	0	0	0	0	0	0	0	12	12
55-64	12	0	12	0	0	0	0	12	12
65-75	0	0	0	0	0	0	0	0	0
Total	12	0	12	0	0	0	0	24	24

Age	Member Months (Angina With Comorbidity)			Member Months (Angina Without Comorbidity)			Member Months (CAD With Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44	0	0	0	0	12	12	12	12	24
45-54	0	12	12	0	0	0	12	48	60
55-64	0	12	12	0	0	0	48	76	124
65-75	0	0	0	0	0	0	0	0	0
Total	0	24	24	0	12	12	72	136	208

Pharmacy Benefit Member Months

Age	Member Months (CHF With Comorbidity)			Member Months (CHF Without Comorbidity)			Member Months (AMI With Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44	0	0	0	0	0	0	0	0	0
45-54	0	0	0	0	0	0	0	12	12
55-64	12	0	12	0	0	0	0	12	12
65-75	0	0	0	0	0	0	0	0	0
Total	12	0	12	0	0	0	0	24	24

Age	Member Months (Angina With Comorbidity)			Member Months (Angina Without Comorbidity)			Member Months (CAD With Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-44	0	0	0	0	12	12	12	12	24
45-54	0	12	12	0	0	0	12	48	60
55-64	0	12	12	0	0	0	48	76	124
65-75	NR	0	0	0	0	0	0	0	0
Total	0	24	24	0	12	12	72	136	208

CHF with Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure - Inpatient	Surgery and Procedure - Outpatient	Pharmacy	Inpatient Facility Discharges	ED Visits
18-44	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
45-54	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
55-64	M	42298	1739	2264	2289	0	1688	3	3
	F	0	0	0	0	0	0	0	0
	Total	$42,298.00	$1,739.00	$2,264.00	$2,289.00	$0.00	$1,688.00	3	3
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	M	$42,298.00	$1,739.00	$2,264.00	$2,289.00	$0.00	$1,688.00	3	3

Total	**F**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	Total	$42,298.00	$1,739.00	$2,264.00	$2,289.00	$0.00	$1,688.00	3	3
CHF without Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure - Inpatient**	**Surgery and Procedure - Outpatient**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
45-54	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
55-64	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
AMI with Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure - Inpatient**	**Surgery and Procedure - Outpatient**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
45-54	**M**	0	0	0	0	0	0	0	0
	F	6629	526	1061	0	0	2859	1	1

	Total	$6,629.00	$526.00	$1,061.00	$0.00	$0.00	$2,859.00	1	1
55-64	**M**	0	0	0	0	0	0	0	0
	F	14127	274	2500	0	251	12509	2	11
	Total	$14,127.00	$274.00	$2,500.00	$0.00	$251.00	$12,509.00	2	11
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	F	$20,756.00	$800.00	$3,561.00	$0.00	$251.00	$15,368.00	3	12
	Total	$20,756.00	$800.00	$3,561.00	$0.00	$251.00	$15,368.00	3	12

AMI without Comorbidity

Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure - Inpatient**	**Surgery and Procedure - Outpatient**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
45-54	**M**	4890	167	438	0	0	3683	1	0
	F	0	0	0	0	0	0	0	0
	Total	$4,890.00	$167.00	$438.00	$0.00	$0.00	$3,683.00	1	0
55-64	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$4,890.00	$167.00	$438.00	$0.00	$0.00	$3,683.00	1	0
	F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	Total	$4,890.00	$167.00	$438.00	$0.00	$0.00	$3,683.00	1	0

Angina with Comorbidity

Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**	**Total Service Frequency by Service Category, Age, and**

Age	Sex	Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure - Inpatient	Surgery and Procedure - Outpatient	Pharmacy	Inpatient Facility Discharges	ED Visits
18-44	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
45-54	M	0	0	0	0	0	0	0	0
	F	0	760	740	0	0	1435	0	12
	Total	$0.00	$760.00	$740.00	$0.00	$0.00	$1,435.00	0	12
55-64	M	0	0	0	0	0	0	0	0
	F	0	167	638	0	0	3155	0	0
	Total	$0.00	$167.00	$638.00	$0.00	$0.00	$3,155.00	0	0
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	M	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	F	$0.00	$927.00	$1,378.00	$0.00	$0.00	$4,590.00	0	12
	Total	$0.00	$927.00	$1,378.00	$0.00	$0.00	$4,590.00	0	12

Angina without Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure - Inpatient	Surgery and Procedure - Outpatient	Pharmacy	Inpatient Facility Discharges	ED Visits
18-44	M	0	0	0	0	0	0	0	0
	F	0	0	719	0	0	740	0	6
	Total	$0.00	$0.00	$719.00	$0.00	$0.00	$740.00	0	6
45-54	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
55-64	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
65-75	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0

	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	F	$0.00	$0.00	$719.00	$0.00	$0.00	$740.00	0	6
	Total	$0.00	$0.00	$719.00	$0.00	$0.00	$740.00	0	6
CAD with Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure - Inpatient**	**Surgery and Procedure - Outpatient**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	8115	408	1384	0	145	6369	1	4
	F	0	0	339	0	0	198	0	0
	Total	$8,115.00	$408.00	$1,723.00	$0.00	$145.00	$6,567.00	1	4
45-54	**M**	0	0	271	0	0	3036	0	0
	F	6192	389	3023	530	0	9639	1	6
	Total	$6,192.00	$389.00	$3,294.00	$530.00	$0.00	$12,675.00	1	6
55-64	**M**	0	0	2208	0	1975	11110	0	0
	F	20363	1488	6202	2960	2024	16642	3	4
	Total	$20,363.00	$1,488.00	$8,410.00	$2,960.00	$3,999.00	$27,752.00	3	4
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$8,115.00	$408.00	$3,863.00	$0.00	$2,120.00	$20,515.00	1	4
	F	$26,555.00	$1,877.00	$9,564.00	$3,490.00	$2,024.00	$26,479.00	4	10
	Total	$34,670.00	$2,285.00	$13,427.00	$3,490.00	$4,144.00	$46,994.00	5	14
CAD without Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure - Inpatient**	**Surgery and Procedure - Outpatient**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0

45-54	**M**	0	0	0	0	0	0	0	0
	F	0	579	1091	265	0	1734	0	01
	Total	$0.00	$579.00	$1,091.00	$265.00	$0.00	$1,734.00	0	1
55-64	**M**	0	0	0	0	0	0	0	0
	F	0	0	351	0	0	1550	0	0
	Total	$0.00	$0.00	$351.00	$0.00	$0.00	$1,550.00	0	0
65-75	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	**M**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	F	$0.00	$579.00	$1,442.00	$265.00	$0.00	$3,284.00	0	1
	Total	$0.00	$579.00	$1,442.00	$265.00	$0.00	$3,284.00	0	1

Cardiovascular Conditions Totals

Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**	**Surgery and Procedure - Outpatient - PMPM**	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/1,000 Member Years**
18-44	**M**	$676.25	$34.00	$115.33	$0.00	$12.08	$530.75	1,000.00	4,000.00
	F	$0.00	$0.00	$44.08	$0.00	$0.00	$39.08	0.00	3,000.00
	Total	$225.42	$11.33	$67.83	$0.00	$4.03	$202.97	333.33	3,333.33
45-54	**M**	$203.75	$6.96	$29.54	$0.00	$0.00	$279.96	500.00	0.00
	F	$152.63	$26.83	$70.42	$9.46	$0.00	$186.51	285.71	2,857.14
	Total	$163.99	$22.42	$61.33	$7.36	$0.00	$207.28	333.33	2,222.22
55-64	**M**	$704.97	$28.98	$74.53	$38.15	$32.92	$213.30	600.00	600.00
	F	$307.95	$17.22	$86.53	$26.43	$20.31	$302.29	535.71	1,607.14
	Total	$446.44	$21.33	$82.34	$30.52	$24.71	$271.24	558.14	1,255.81
65-75	**M**	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA
	Total	NA	NA	NA	NA	NA	NA	NA	NA
Total	**M**	$576.07	$24.10	$68.39	$23.84	$22.08	$269.65	625.00	875.00
	F	$215.05	$19.01	$75.75	$17.07	$10.34	$229.37	381.82	2,236.36

	Total	$324.73	$20.56	$73.51	$19.13	$13.91	$241.60	455.70	1,822.78

Member Months (AMI Without		
Male	**Female**	**Total**
0	0	0
12	0	12
0	0	0
0	0	0
12	0	12
Member Months (CAD Without		
Male	**Female**	**Total**
0	0	0
0	12	12
0	12	12
0	0	0
0	24	24

Member Months (AMI Without		
Male	Female	Total
0	0	0
12	0	12
0	0	0
0	0	0
12	0	12
Member Months (CAD Without		
Male	Female	Total
0	0	0
0	12	12
0	12	12
0	0	0
0	24	24

Relative Resource Use for People With Hypertension (RHY)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Medical and Pharmacy Benefit Member Months	
Category	**Eligible Population**
Total	184
Exclusions (required)	245

Medical and Pharmacy Benefit Member Months						
Age	**Medical Benefit Member Months**			**Pharmacy Benefit Member Months**		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
18-44	329	611	940	329	597	926
45-54	268	324	592	268	324	592
55-64	302	345	647	302	334	636
65-85	0	0	0	0	0	0
Total	899	1,280	2,179	899	1,255	2,154

Uncomplicated Hypertension									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	**Surgery and Procedure -**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
18-44	**M**	195583	5671	17397	5312	6284	29360	14	28
	F	196248	8715	34485	3565	5461	34387	16	46
	Total	$391,831.0	$14,386.00	$51,882.00	$8,877.00	$11,745.00	$63,747.00	30	74
45-54	**M**	100875	3887	13973	15607	2085	19059	5	15
	F	30067	1464	17872	2443	2813	22869	4	31
	Total	$130,942.0	$5,351.00	$31,845.00	$18,050.00	$4,898.00	$41,928.00	9	46
55-64	**M**	103841	1836	11692	7286	5219	30516	7	15
	F	4988	513	15540	4715	7457	30345	1	5
	Total	$108,829.0	$2,349.00	$27,232.00	$12,001.00	$12,676.00	$60,861.00	8	20
65-85	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0

Total	**M**	$400,299.0	$11,394.00	$43,062.00	$28,205.00	$13,588.00	$78,935.00	26	58
	F	$231,303.0	$10,692.00	$67,897.00	$10,723.00	$15,731.00	$87,601.00	21	82
	Total	$631,602.0	$22,086.00	$110,959.0	$38,928.00	$29,319.00	$166,536.0	47	140
Uncomplicated Hypertension Totals									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**	**Surgery and Procedure - Outpatient - PMPM**	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/ 1,000 Member Years**
18-44	**M**	$594.48	$17.24	$52.88	$16.15	$19.10	$89.24	510.64	1,021.28
	F	$321.19	$14.26	$56.44	$5.83	$8.94	$57.60	314.24	903.44
	Total	$416.84	$15.30	$55.19	$9.44	$12.49	$68.84	382.98	944.68
45-54	**M**	$376.40	$14.50	$52.14	$58.24	$7.78	$71.12	223.88	671.64
	F	$92.80	$4.52	$55.16	$7.54	$8.68	$70.58	148.15	1,148.15
	Total	$221.19	$9.04	$53.79	$30.49	$8.27	$70.82	182.43	932.43
55-64	**M**	$343.84	$6.08	$38.72	$24.13	$17.28	$101.05	278.15	596.03
	F	$14.46	$1.49	$45.04	$13.67	$21.61	$90.85	34.78	173.91
	Total	$168.21	$3.63	$42.09	$18.55	$19.59	$95.69	148.38	370.94
65-85	**M**	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA
	Total	NA	NA	NA	NA	NA	NA	NA	NA
Total	**M**	$445.27	$12.67	$47.90	$31.37	$15.11	$87.80	347.05	774.19
	F	$180.71	$8.35	$53.04	$8.38	$12.29	$69.80	196.88	768.75
	Total	$289.86	$10.14	$50.92	$17.87	$13.46	$77.31	258.83	771.00

Relative Resource Use for People With COPD (RCO)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Eligible Population	
Category	**Eligible Population**
Total	26
Exclusions (required)	0
With Comorbidity	24
Without Comorbidity	2

Age	Member Benefit Member Months						Pharmacy Benefi		
	Member Months (With Comorbidity)			Member Months (Without Comorbidity)			Member Months (With Comorbidity)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
42-44	0	48	48	12	0	12	0	48	48
45-64	125	108	233	0	12	12	125	108	233
65-74	0	0	0	0	0	0	0	0	0
75+	0	0	0	0	0	0	0	0	0
Total	125	156	281	12	12	24	125	156	281

COPD with Comorbidity

Age	Sex	Total Standard Cost by Service Category, Age, and Gender						Total Service Frequency by Service Category, Age, and	
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
42-44	**M**	0	0	0	0	0	0	0	0
	F	10731	700	5656	0	235	8527	2	7
	Total	$10,731.00	$700.00	$5,656.00	$0.00	$235.00	$8,527.00	2	7
45-64	**M**	22437	1493	8543	0	3807	33626	2	6
	F	37571	16748	9004	2172	1646	37453	3	7
	Total	$60,008.00	$18,241.00	$17,547.00	$2,172.00	$5,453.00	$71,079.00	5	13
65-74	**M**	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
	M	0	0	0	0	0	0	0	0

75+	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	M	$22,437.00	$1,493.00	$8,543.00	$0.00	$3,807.00	$33,626.00	2	6
	F	$48,302.00	$17,448.00	$14,660.00	$2,172.00	$1,881.00	$45,980.00	5	14
	Total	$70,739.00	$18,941.00	$23,203.00	$2,172.00	$5,688.00	$79,606.00	7	20
COPD without Comorbidity									
Age	**Sex**	**Total Standard Cost by Service Category, Age, and Gender**						**Total Service Frequency by Service Category, Age, and**	
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	**Surgery and Procedure -**	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
42-44	M	0	0	194	0	0	362	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$194.00	$0.00	$0.00	$362.00	0	0
45-64	M	0	0	0	0	0	0	0	0
	F	0	0	927	0	0	2253	0	0
	Total	$0.00	$0.00	$927.00	$0.00	$0.00	$2,253.00	0	0
65-74	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
75+	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0	0
Total	M	$0.00	$0.00	$194.00	$0.00	$0.00	$362.00	0	0
	F	$0.00	$0.00	$927.00	$0.00	$0.00	$2,253.00	0	0
	Total	$0.00	$0.00	$1,121.00	$0.00	$0.00	$2,615.00	0	0
COPD Totals									
		Total Standard Cost by Service Category, Age, and Gender						**Total Service Frequency by Service Category, Age, and**	

Age	Sex	Inpatient Facility - PMPM	E & M - Inpatient - PMPM	E & M - Outpatient - PMPM	Surgery and Procedure - Inpatient - PMPM	Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years	ED Visits/ 1,000 Member Years
42-44	M	$0.00	$0.00	$16.17	$0.00	$0.00	$30.17	0.00	0.00
	F	$223.56	$14.58	$117.83	$0.00	$4.90	$177.65	500.00	1,750.00
	Total	$178.85	$11.67	$97.50	$0.00	$3.92	$148.15	400.00	1,400.00
45-64	M	$179.50	$11.94	$68.34	$0.00	$30.46	$269.01	192.00	576.00
	F	$313.09	$139.57	$82.76	$18.10	$13.72	$330.88	300.00	700.00
	Total	$244.93	$74.45	$75.40	$8.87	$22.26	$299.31	244.90	636.73
65-74	M	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA
	Total	NA	NA	NA	NA	NA	NA	NA	NA
75+	M	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA
	Total	NA	NA	NA	NA	NA	NA	NA	NA
Total	M	$163.77	$10.90	$63.77	$0.00	$27.79	$248.09	175.18	525.55
	F	$287.51	$103.86	$92.78	$12.93	$11.20	$287.10	357.14	1,000.00
	Total	$231.93	$62.10	$79.75	$7.12	$18.65	$269.58	275.41	786.89

t Member Months		
Member Months (Without Comorbidity)		
Male	Female	Total
12	0	12
0	12	12
0	0	0
0	0	0
12	12	24

Board Certification (BCR)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Type of Physician	Number of Physicians	Board Certification	
		Number	Percent
Family Medicine	85	78	91.76%
Internal Medicine	72	59	81.94%
OB/GYN physicians	52	41	78.85%
Pediatricians	44	39	88.64%
Geriatricians	5	4	80.00%
Other physician specialists	282	230	81.56%

Enrollment by Product Line: Total (ENPA)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	Male Member Months	Female Member Months	Total Member Months
<1	7167	6515	13,682
1-4	24175	22444	46,619
5-9	23772	22686	46,458
10-14	19296	19124	38,420
15-17	10942	10753	21,695
18-19	4484	6260	10,744
0-19 Subtotal	89,836	87,782	177,618
0-19 Subtotal: %	77.08%	61.88%	68.74%
20-24	4370	12990	17,360
25-29	3976	11190	15,166
30-34	3384	8312	11,696
35-39	3313	6570	9,883
40-44	3192	4539	7,731
20-44 Subtotal	18,235	43,601	61,836
20-44 Subtotal: %	15.65%	30.74%	23.93%
45-49	2911	3863	6,774
50-54	2335	2907	5,242
55-59	2095	2285	4,380
60-64	1136	1413	2,549
45-64 Subtotal	8,477	10,468	18,945
45-64 Subtotal: %	7.27%	7.38%	7.33%
65-69	0	0	0
70-74	0	0	0
75-79	0	0	0
80-84	0	0	0
85-89	0	0	0
>=90	0	0	0
>=65 Subtotal	0	0	0
>=65 Subtotal: %	0.00%	0.00%	0.00%
Age Unknown	0	0	0
Total	116,548	141,851	258,399

Enrollment by Product Line: Dual Eligibles (ENPB)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	Male Member Months	Female Member Months	Total Member Months
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by Product Line: Disabled (ENPC)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019,			
Age	Male Member Months	Female Member Months	Total Member Months
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by Product Line: Other (ENPD)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	**Male Member Months**	**Female Member Months**	**Total Member Months**
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by State (EBS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID:	
State	Number
Alabama	0
Alaska	0
Arizona	1
Arkansas	0
California	12
Colorado	2
Connecticut	0
Delaware	0
District of Columbia	0
Florida	0
Georgia	1
Hawaii	22554
Idaho	0
Illinois	0
Indiana	0
Iowa	0
Kansas	0
Kentucky	0
Louisiana	0
Maine	0
Maryland	0
Massachusetts	0
Michigan	0
Minnesota	1
Mississippi	0
Missouri	0
Montana	0
Nebraska	0
Nevada	1
New Hampshire	0
New Jersey	1
New Mexico	0
New York	0
North Carolina	0
North Dakota	0
Ohio	0
Oklahoma	0
Oregon	1
Pennsylvania	0
Rhode Island	0
South Carolina	0
South Dakota	0
Tennessee	0
Texas	4
Utah	5
Vermont	0
Virginia	0
Washington	0
West Virginia	0
Wisconsin	0
Wyoming	0
American Samoa	0
Federated States of Micronesia	0

Guam	0
Commonwealth of Northern Marianas	0
Puerto Rico	0
Virgin Islands	0
Other	0
TOTAL	22,583

Race/Ethnicity Diversity of Membership (RDM)									
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)									
Eligible Population									
Category	**Value**								
Total unduplicated membership during the measurement year	27144								
Data Source	Other								
Race	**Sex**	**Hispanic or Latino (any race)**		**Not Hispanic or Latino**		**Unknown Ethnicity**		**Total**	
		Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
White	**M**	0	0.00%	2711	9.99%	0	0.00%	2,711	9.99%
	F	0	0.00%	3327	12.26%	0	0.00%	3,327	12.26%
	Total	0	0.00%	6,038	22.24%	0	0.00%	6,038	22.24%
Black or African American	**M**	0	0.00%	159	0.59%	0	0.00%	159	0.59%
	F	0	0.00%	190	0.70%	0	0.00%	190	0.70%
	Total	0	0.00%	349	1.29%	0	0.00%	349	1.29%
American-Indian and Alaska Native	**M**	0	0.00%	18	0.07%	0	0.00%	18	0.07%
	F	0	0.00%	20	0.07%	0	0.00%	20	0.07%
	Total	0	0.00%	38	0.14%	0	0.00%	38	0.14%
Asian	**M**	0	0.00%	1853	6.83%	0	0.00%	1,853	6.83%
	F	0	0.00%	2211	8.15%	0	0.00%	2,211	8.15%
	Total	0	0.00%	4,064	14.97%	0	0.00%	4,064	14.97%
Native Hawaiian and Other Pacific Islanders	**M**	0	0.00%	3472	12.79%	0	0.00%	3,472	12.79%
	F	0	0.00%	4245	15.64%	0	0.00%	4,245	15.64%
	Total	0	0.00%	7,717	28.43%	0	0.00%	7,717	28.43%
Some Other Race	**M**	470	1.73%	33	0.12%	0	0.00%	503	1.85%
	F	540	1.99%	57	0.21%	0	0.00%	597	2.20%
	Total	1,010	3.72%	90	0.33%	0	0.00%	1,100	4.05%
Two or More Races	**M**	0	0.00%	408	1.50%	0	0.00%	408	1.50%
	F	0	0.00%	515	1.90%	0	0.00%	515	1.90%
	Total	0	0.00%	923	3.40%	0	0.00%	923	3.40%
Unknown	**M**	0	0.00%	733	2.70%	2441	8.99%	3,174	11.69%
	F	0	0.00%	902	3.32%	2839	10.46%	3,741	13.78%
	Total	0	0.00%	1,635	6.02%	5,280	19.45%	6,915	25.48%
Total	**M**	470	1.73%	9,387	34.58%	2,441	8.99%	12,298	45.31%
	F	540	1.99%	11,467	42.25%	2,839	10.46%	14,846	54.69%

	Total	1,010	3.72%	20,854	76.83%	5,280	19.45%	27,144	100.00%

Totals	
Measure	**Percentage**
Percentage of plan members with known race information	74.52%
Percentage of plan members with known ethnicity information	80.55%

Language Diversity of Membership (LDM)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Eligible Population			
Category	**Value**		
Total unduplicated membership during the measurement year:	27144		
Data Source	Other		
Demand for Language Interpretation Services			
Demand for Language Interpretation Services	**Sex**	**Number**	**Percentage**
Need/want an interpreter? Yes	**M**	0	0.00%
	F	0	0.00%
	Total	0	0.00%
Need/want an interpreter? No	**M**	0	0.00%
	F	0	0.00%
	Total	0	0.00%
Need/want an interpreter? Unknown	**M**	12298	45.31%
	F	14846	54.69%
	Total	27,144	100.00%
Total	**M**	12,298	45.31%
	F	14,846	54.69%
	Total	27,144	100.00%
Percentage of members with known interpretation needs			0.00%
Spoken Language at Home			
Spoken Language at Home	**Sex**	**Number**	**Percentage**
English	**M**	1631	6.01%
	F	1697	6.25%
	Total	3,328	12.26%
Spanish (or Spanish Creole)	**M**	22	0.08%
	F	41	0.15%
	Total	63	0.23%
Other Indo-European Languages (e.g., French or French Creole, Italian, Portuguese or Portuguese	**M**	0	0.00%
	F	0	0.00%
	Total	0	0.00%
Asian and Pacific Island Languages (e.g., Chinese, Japanese, Korean, Mon-Khmer, Cambodian, Miao,	**M**	1095	4.03%
	F	1400	5.16%
	Total	2,495	9.19%
Other Languages (e.g., Navajo, Other Native North American languages, Hungarian, Arabic, Hebrew, African	**M**	6908	25.45%
	F	8616	31.74%
	Total	15,524	57.19%
Unknown	**M**	2642	9.73%
	F	3092	11.39%
	Total	5,734	21.12%
Total	**M**	12,298	45.31%
	F	14,846	54.69%
	Total	27,144	100.00%
Percentage of members with known spoken language			78.88%

Weeks of Pregnancy at Time of Enrollment in MCO (WOP)		
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)		
Measurement Year		
Measurement Year	2009	
Weeks of Pregnancy	Number	Percentage
< 0 weeks	148	27.92%
1-12 weeks	377	71.13%
13-27 weeks	5	0.94%
28 or more weeks	0	0.00%
Unknown	0	0.00%
Total	530	100.00%

Total Membership (TLM)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Product/Product Line	Total Number of Members*
HMO (Total)	213,463
Medicaid	24012
Commercial	165950
Medicare (cost or risk)	23501
Other	0
PPO (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
POS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
FFS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
Total	213,463
* Total number of members in each category as of December 31 of the measurement year.	

HEDIS® 2011
COMPLIANCE AUDIT™
FINAL REPORT OF FINDINGS
for
KAISER PERMANENTE HAWAII
QUEST

July 2011

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

for **Kaiser Permanente Hawaii QUEST**

Final Audit Statement

This section includes the fully executed Final Audit Statement.

Summary Information

This section includes basic audit information, including the audit organization information, audit validation signatures, name of the managed care organization (MCO) undergoing the audit, audit team composition, and a summary of pre-onsite activities.

Information Systems Capabilities Assessment

This section includes a summary of the auditor's assessment findings of the MCO's information systems (IS) capabilities and any impact on Healthcare Effectiveness Data and Information Set (HEDIS®) reporting. Information includes facts on claims, membership and provider data, medical record review processes, supplemental data, data integration, data control, and measure calculation processes.

HEDIS Measure Determination Assessment

This section describes the purpose of the HEDIS Measure Determination (HD) Assessment in addition to the methods that the audit team used to evaluate the MCO's compliance with the NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5.

Survey Sample Frame Findings

This section describes the auditor's methodology for survey sample frame validation and displays the validation results.

Medical Record Review Validation Findings

This section describes the auditor's methodology for medical record review validation and displays the final medical record review validation results.

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Audit Results and Associated Rates

This section discusses the audit results that can be assigned to a measure and the rationale for their selection. The completed final data submission can be found in Appendix A.

Final Audit Statement

We have examined **Kaiser Permanente Hawaii QUEST's (Kaiser's)** submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS Technical Specifications for all measures presented at the time of our audit.

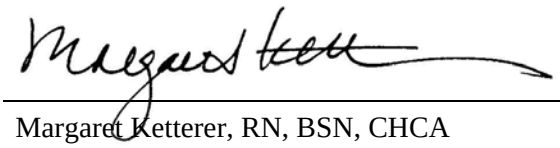
This report is **Kaiser** management's responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submission presents fairly, in all material respects, the organization's performance with respect to the HEDIS Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the organization.

In our opinion, **Kaiser's** submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity, and enforceability as original signatures submitted on paper.

Richard G. Potter, CPA, MBA, CHCA
(NCQA-Certified HEDIS Compliance Auditor)

July 15, 2011
(Date)



Margaret Ketterer, RN, BSN, CHCA
(Responsible Officer)

July 15, 2011
(Date)

Organization ID: 124
Submission ID(s): 4019

About the NCQA-Licensed Audit Organization

Health Services Advisory Group, Inc. (HSAG) is an organization licensed by the National Committee for Quality Assurance (NCQA) to perform HEDIS audit reviews.[3-1]

NCQA-Licensed Organization
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016

Audit Director
Margaret Ketterer, RN, BSN, CHCA
Executive Director, Audits/State and Corporate Services

Lead Auditor
Richard G. Potter, CPA, MBA, CHCA
Executive Vice President & Chief Operating Officer

MCO and Audit Information

HSAG conducted the type of audit described below. Basic information about the MCO also appears in the table, including the office location(s) involved in the 2011 HEDIS Compliance Audit. All report preparation activity performed by the MCO was conducted at the address shown below.

Audit Scope:	Medicaid HEDIS Reporting
Audit Timeline:	January 2011 to June 2011
MCO:	Kaiser
MCO Location(s):	711 Kapiolani Boulevard Honolulu, HI 96813
Contact:	Ms. Jill McCready, MSPH
Title:	Senior Planning Analyst, HEDIS Lead
Telephone:	(808) 432-5223
E-Mail:	jill.a.mccready@kp.org
NCQA Organization ID:	124
NCQA Submission ID(s):	4019
Certified Survey Vendor:	HSAG
Certified Software Vendor:	Not Applicable, Internally Developed Code Used

[3-1] NCQA HEDIS® Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Audit Team Composition

The HSAG audit team is composed of both NCQA-Certified and non-certified individuals. The team is assembled based on the full complement of skills required for the audit and the particular requirements of the MCO. Some team members, including the lead auditor, participated in the onsite meetings at the MCO office; others conduct their work at HSAG offices. **Kaiser's** audit team included the following members in the designated positions. Each individual's particular expertise is described in the following table.

Audit Team						
Team Member	**Certified Auditor (Yes/No)**	**Role and Level of Effort**	**Dates of Involvement**	**Education**	**Years of HEDIS Experience**	**Years of Audit Experience**
Richard G. Potter, CPA, MBA, CHCA	Yes	Lead Auditor; Executive Vice President & Chief Operating Officer	January 2011 to June 2011	Master of Business Administration (MBA); Bachelor of Science (BS)	6	14
Bonnie Marsh, BSN, MA	No	Co-Auditor & Executive Director, State and Corporate Services, Hawaii Office	January 2011 to June 2011	Master of Arts in Organizational Management (MA); Bachelor of Science in Nursing (BSN)	1	17
Margaret Ketterer, RN, BSN, CHCA	Yes	Executive Director, Audits & Practice Leader	January 2011 to June 2011	Bachelor of Science in Nursing (BSN)	14	14
Melissa C. Brashears, CPA, MBA	No	Executive Director, Audits	January 2011 to June 2011	Master of Business Administration (MBA); Bachelors of Business Administration (BA)	1	20
David Mabb, MS, CHCA	Yes	Source Code Review Manager & Associate Director, Audits	January 2011 to June 2011	Master of Science (MS)	17	13
Marilea Rose, RN, BA	No	Medical Record Review Over-read Process Supervisor	January 2011 to June 2011	Bachelor of Arts (BA)	14	14
Dan Moore, MPA	No	Source Code Reviewer	January 2011 to June 2011	Master of Public Administration (MPA); Bachelor of Bus. Info. Systems	11	15
Tammy GianFrancisco	No	Project Coordinator	January 2011 to June 2011	N/A	8	8
Maricris Kueny	No	Administrative Assistant	January 2011 to June 2011	N/A	7	7
Kelly Stewart, BA, HCSA	No	Project Coordinator	January 2011 to June 2011	Bachelor of Arts (BA)	2	2

Measures for Reporting Year 2011

HSAG reviewed the selected set of measures in the following table.

Audited Measures		
	Measure Name	**Product Line**
1	Childhood Immunization Status	Medicaid
2	Breast Cancer Screening	Medicaid
3	Chlamydia Screening in Women	Medicaid
4	Cholesterol Management for Patients with Cardiovascular Conditions	Medicaid
5	Comprehensive Diabetes Care	Medicaid
6	Ambulatory Care (ED visits & outpatient visit indicators)	Medicaid

Supplemental Database Review and Findings

The HEDIS Technical Specifications allow MCOs to include supplemental data in the collection and calculation of the HEDIS measures if the MCOs follow the NCQA rules and guidelines for collection, validation, and use of these data. Supplemental data are defined as any health care delivery information that is available outside of the health plan's claims/encounter data system. Auditors must categorize the supplemental data as external (provided by an external party) or internal (generated within the health plan), and standard (provided in a standardized, well-documented format) or nonstandard (formats differ from source to source). HSAG determined if **Kaiser** used any supplemental data and if such data were used, HSAG performed the following review activities:

- Review of policies and procedures for collection and validation of the data.
- Review of the data format and data elements.
- Primary source verification of a randomly selected sample of records against the original data source, as applicable.

The results of this review are presented in the table below. A discussion of supplemental database findings is presented in Section 4: Information Systems Capability Assessment.

Supplemental Database Findings				
Database Name	**Classification**	**Measures Impacted**	**Primary Source Verification**	**Audit Results**
N/A	N/A	N/A	N/A	N/A

Introduction

The audit team reviewed **Kaiser's** information systems (IS) capabilities for accurate HEDIS reporting. The audit team focused specifically on aspects of **Kaiser's** systems that could impact the HEDIS reporting set.

For the purpose of HEDIS Compliance Auditing, the term "information systems" was used broadly to include **Kaiser's** computer and software environment, data collection procedures, applicable supplemental databases, and abstraction of medical records for hybrid measures. In addition, the IS evaluation included a review of any manual processes that may have been used for HEDIS reporting. In summary, the audit team determined if **Kaiser** had the automated systems, information management practices, processing environment, and control procedures to access, capture, translate, analyze, and report each HEDIS measure.

In accordance with the 2011 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, Volume 5, the audit team evaluated **Kaiser's** IS compliance with NCQA's IS standards, which detail the minimum requirements that should be met, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the audit team evaluated the impact on HEDIS reporting capabilities. An MCO may not be fully compliant with many of the IS standards, but may be fully able to report all measures.

Please note that there are certain IS standards that address data (e.g., mental health services) that are required for the full HEDIS reporting set, but are not specifically required for the selected set of measures (if applicable). The auditors' evaluation of **Kaiser's** IS capabilities is, therefore, more comprehensive than the processes required to produce the selected measures.

The section that follows is a summary of **Kaiser's** compliance with NCQA's IS standards.

Standard	Audit Findings	Impact on Reporting
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry		
IS 1.1 Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) are used and all characters are captured. **IS 1.2** Principal codes are identified and secondary codes are captured. **IS 1.3** Nonstandard coding schemes are fully documented and mapped back to industry standard codes. **IS 1.4** Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards. **IS 1.5** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for measure reporting. **IS 1.6** The organization continually assesses data completeness and takes steps to improve performance. **IS 1.7** The organization regularly monitors vendor performance against expected performance standards.	**Kaiser** was compliant with IS 1.0. Adequate procedures existed and were observed to be effective, ensuring all paper information, which accounted for approximately eight to ten percent of total claims and encounters, was submitted accurately and captured into the KPOPS claims processing system. There were minimal edits in KPOPS to detect claims processing errors, however, a monthly claims audit was performed and processing accuracy levels were met throughout 2010. KPHC was the system that processed internal encounters and accounted for over 90 percent of all claims and encounters. Edits were in place to ensure codes were valid and complete. KPHC utilized internal service codes that were cross-walked to industry standard codes. An encounter was created for each scheduled appointment within a **Kaiser** facility and reports were generated that identified open encounters. These reports were reviewed regularly and internal **Kaiser** providers were notified to complete any open encounters.	No impact

Standard	Audit Findings	Impact on Reporting
IS 2.0 Enrollment Data—Data Capture, Transfer and Entry		
IS 2.1 The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy. **IS 2.2** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files. **IS 2.3** The organization continually assesses data completeness and takes steps to improve performance. **IS 2.4** The organization regularly monitors vendor performance against expected performance standards.	**Kaiser** was compliant with IS 2.0. All enrollment data (initial, changes, terminations) were received from Med-QUEST, the state Medicaid agency. Additions, changes, and terminations were received and processed daily at **Kaiser's** Consolidated Service Center located in Denver, Colorado. Discrepancies were identified and resolved daily. Monthly, a full reconciliation was performed between the enrollment table in KPHC and the HIPAA 834 full membership file received from Med-QUEST. Reconciliations were performed timely and discrepancies were also resolved timely.	No impact

Standard	Audit Findings	Impact on Reporting
IS 3.0 Practitioner Data—Data Capture, Transfer and Entry		
IS 3.1 Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting. **IS 3.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy. **IS 3.3** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 3.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 3.5** The organization regularly monitors vendor performance against expected performance standards.	**Kaiser** was compliant with IS 3.0. No issues were identified affecting the processing of provider data. Within the KPHC and KPOPS systems, provider types and specialties were determined as required for the reporting of certain HEDIS measures.	No impact

Standard	Audit Findings	Impact on Reporting
IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction and Oversight		
IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off). **IS 4.2** Retrieval and abstraction of data from medical records is reliably and accurately performed. **IS 4.3** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. **IS 4.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 4.5** The organization regularly monitors vendor performance against expected performance standards.	**Kaiser** was fully compliant with the IS 4.0 reporting process. **Kaiser's** source code was reviewed and approved by HSAG. **Kaiser** staff collected medical record documentation via the plan's centralized electronic medical record (EMR) system. All data were entered into standardized spreadsheets. The spreadsheets were pre-populated with encounter data and contained front end edits that calculated data ranges and checked for duplicate data within 14 days. Once completed, the tools contained the full set of data for each measure. Reviewer qualifications and the processes in place for training, procurement, abstraction, IRR and data entry were sufficient to ensure reliability of the data collected. There were no changes to the medical record review process; therefore, a convenience sample was not required. **Kaiser** passed the over-read requirement for the following two measures: Comprehensive Diabetes Care - Eye Exam (retinal) Performed indicator and Comprehensive Diabetes Care - Medical Attention for Nephropathy indicator.	

Standard	Audit Findings	Impact on Reporting
IS 5.0 Supplemental Data—Capture, Transfer and Entry		
IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. **IS 5.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy. **IS 5.3** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 5.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 5.5** The organization regularly monitors vendor performance against expected performance standards.	**Kaiser** was compliant with IS 5.0. There were no nonstandard external supplemental data sources that were used to produce the HEDIS measures.	No impact

Standard	Audit Findings	Impact on Reporting
IS 6.0 Member Call Center Data—Capture, Transfer and Entry		
IS 6.1 Member call center data are reliably and accurately captured.	IS 6.0 was not applicable to the measures under the scope of the Hawaii Medicaid audit.	Not applicable

Standard	Audit Findings	Impact on Reporting
IS 7.0 Data Integration—Accurate Reporting, Control Procedures That Support HEDIS or Measure Reporting Integrity		
IS 7.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. **IS 7. 2** Data transfers to repository from transaction files are accurate. **IS 7.3** File consolidations, extracts and derivations are accurate. **IS 7.4** Repository structure and formatting are suitable for measures and enable required programming efforts. **IS 7.5** Report production is managed effectively and operators perform appropriately. **IS 7.6** Measure reporting software is managed properly with regard to development, methodology, documentation, revision control and testing. **IS 7.7** Physical control procedures ensure measure data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection.	**Kaiser** was compliant with IS 7.0. Primary source verification did not identify any issues for the measures under review. Several systems that were comprised of claims, encounters, membership, and practitioner data were needed to derive the HEDIS rates. Data from each system were validated and audit checks were performed to ensure the accuracy and completeness of the files. **Kaiser** produced source code internally without a software vendor. Minor issues were identified during the source code review that were determined to not materially affect the onsite primary source verification and all source code issues were subsequently resolved. Appropriate backup and security procedures were in place to safeguard data files in the event of a system failure.	No impact

HEDIS Measurement Determination Assessment

In accordance with the 2011 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures,* Volume 5, the audit team evaluated **Kaiser's** compliance with NCQA's HD standards, which detail the minimum requirements that should be met, as well as criteria that any manual processes used to report HEDIS information must meet. When an HD standard was not met, the audit team evaluated the impact on HEDIS reporting capabilities and the impact on any particular measure. An MCO may not be fully compliant with many of the HD standards, but may be fully able to report all measures.

The audit team reviewed **Kaiser's** HD capabilities for compliance with the HEDIS Technical Specifications. The audit team focused specifically on those aspects of **Kaiser's** systems that potentially impact the HEDIS reporting set.

Because **Kaiser** did not use an NCQA-certified vendor to supply the programs to compute the reported measures, HSAG performed a manual source code review and calculations process review of **Kaiser's** HD compliance in accordance with the following standards.

HD 1.0 Denominator Identification

HD 2.0 Sampling

HD 3.0 Numerator Identification

HD 4.0 Algorithmic Compliance

HD 5.0 Outsourced or Delegated Reporting Function

The review results are included in Appendix B of this report.

6. Survey Sample Frame Findings
for Kaiser Permanente Hawaii QUEST

Validation Methods

The audit team validated the sample frame for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey in accordance with NCQA HEDIS Compliance Audit guidelines. The audit included a review of specific reporting methods used for HEDIS/CAHPS measures, including:

1. Detailed evaluation of the computer programming (source code) used to access and manipulate data. If the sample frame was generated using NCQA-certified software, the validation team ensured that the sample frame method received a Met status.
2. Detailed review of the survey eligibility file elements to ensure the accuracy of the file layout against required file specifications, and that the measure specific eligibility flags were present as applicable.
3. Evaluation of membership data completeness.
4. Validation that **Kaiser** selected a certified CAHPS vendor to administer the appropriate survey(s).

Validation Findings

Audit Findings	Description
The survey sample frame was reviewed and approved.	Supports Reporting

7. Medical Record Review Validation Findings

for Kaiser Permanente Hawaii QUEST

Introduction

To validate the medical record review (MRR) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the MCO, including medical record review staff qualifications, training, data collection instruments/tools, interrater reliability (IRR) testing, vendor oversight and the method used for combining MRR data with administrative data; and (2) complete over-read, which involves the reabstraction of a sample of at least two hybrid measures and comparison of the HSAG audit team's results to the MCO's abstraction results.

HSAG's audit team reviewed processes for MRR performance for all reported hybrid measures. Data collection tools and training materials were reviewed by the audit team to verify that all key HEDIS data elements were captured. The audit team determined that **Kaiser's** processes for IRR testing met standards. Additional audit findings related to MRR processes are located under IS Standard 4.0 of the Summary of Key Audit Findings/Compliance with IS Standards.

HSAG's audit team also completed the over-read process and reabstracted records for at least two selected hybrid measures and compared the results to **Kaiser's** findings for the same medical records. For each of the over-read measures, the audit team randomly selected 30 records from the entire population of MRR numerator positives as identified by the MCO. If fewer than 30 medical records were found to meet numerator requirements, all records were reviewed. If an abstraction discrepancy was noted, only critical errors were considered error. A critical error is defined as an abstraction error that affected the final outcome of the numerator event (i.e., changes a positive event to a negative one or vice versa). The over-read process completed the medical record validation portion of the audit and provided an assessment of actual reviewer accuracy.

Using the results of the over-read process, the audit team determined if findings impacted the MCO's audit designation. The goal of the MRR validation was to determine whether the MCO made abstraction errors that significantly biased its final reported rate. HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCOs. If applicable, the NCQA-endorsed t-test was employed to test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If the test revealed that the difference was greater than 5 percent, the MCO's estimate of the positive rate was rejected and the measure could not be reported using the hybrid methodology.

The following table identifies the measure name, the number of records over-read, and the t-test results if applicable, with the corresponding pass/fail determination. Additional commentary on the results of MRR validation can be found in Section 4, IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction and Oversight.

Selected HEDIS Measures for Medical Record Validation			
Measure	**Number of Records Overread**	**T-test Results**	**Pass/Fail**
Comprehensive Diabetes Care - Eye Exam (retinal) Performed	30	N/A	Pass
Comprehensive Diabetes Care-Medical Attention for Nephropathy	14	N/A	Pass

8. Audit Results and Associated Rates
for Kaiser Permanente Hawaii QUEST

Introduction

Each of the audited measures reviewed by the audit team received a final audit result consistent with the NCQA categories listed below. HSAG used a variety of audit methods, including analysis of computer programs, medical record abstraction results, data files, data samples, and staff interviews to produce each measure-specific result. The following table provides the audit finding results that are applicable to the HEDIS measures.

Audit Results and Associated Rates	
Rate/Result	**Comment**
0-XXX	Reportable rate or numeric result for HEDIS measures.
NR	**Not Reported:** 1. Plan chose not to report 2. Calculated rate was materially biased 3. Plan not required to report
NA	**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 (e.g., mental health or chemical dependency)

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible that **Kaiser** prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, **Kaiser** would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive an "NR" result, where appropriate.

Appendix A of this report contains the final data submission and the completed copies of the Audit Review Tables, which display the audit result for each reported measure, the rationale for the assigned result, and any additional comments. The audit result signifies which rates are appropriate for inclusion in external reports.

Appendix A. Final Data Submission
for Kaiser Permanente Hawaii QUEST

Final Data Submission for Kaiser

This appendix contains the final audited data submission worksheet and audit designations for **Kaiser**.

Source Code Review Results for Kaiser

This appendix contains analysis of **Kaiser's** source code review.

Health Plan Name:
Kaiser Foundation Health Plan, Inc. - Hawaii
Health Plan Contact Name:
CEO: Ms. Janet Liang
HEDIS Reporting contact: Jill McCready
Health Plan Contact Email:
HEDIS Reporting contact: Jill.A.McCready@kp.org
Medicaid Population as of 12/31/2010
23,959
Medicaid/Medicare (Medi-Medi) Population as of 12/31/2010
0
Comments:

Ambulatory Care (AMBA)				
HEDIS Reporting Year	2011			
Data Collection Methodology (Admin)	Admin			
Age	Member Months			
<1	13141			
1-9	102045			
10-19	76154			
20-44	68448			
45-64	20746			
65-74	0			
75-84	0			
85+	0			
Unknown	0			
Total	280534			
Age	Outpatient Visits		ED Visits	
	Visits	Visits / 1,000 Member Months	Visits	Visits / 1,000 Member Months
<1	11256	856.56	486	36.98
1-9	28796	282.19	1877	18.39
10-19	15891	208.67	1083	14.22
20-44	21068	307.80	2210	32.29
45-64	9033	435.41	612	29.50
65-74	0	#DIV/0!	0	#DIV/0!
75-84	0	#DIV/0!	0	#DIV/0!
85+	0	#DIV/0!	0	#DIV/0!
Unknown	0	#DIV/0!	0	#DIV/0!
Total	86044	306.72	6268	22.34

Breast Cancer Screening (BCS)	
Data Element	**General Measure Data**
HEDIS Reporting Year	2011
Data collection methodology (administrative)	A
Eligible population	690
Numerator events by administrative data	541
Reported rate	78.41%
Lower 95% confidence interval	75.26%
Upper 95% confidence interval	81.55%

Comprehensive Diabetes Care (CDC)										
Data Element	**HbA1c Testing**	**HbA1c Poor Control (>9.0%)**	**HbA1c Control (<8.0%)**	**HbA1c Control (<7.0%)**	**Eye Exam**	**LDL-C Screening**	**LDL-C Level <100 mg/dL**	**Medical Attention for Nephropathy**	**Blood Pressure Controlled <140/80 mm Hg***	**Blood Pressure Controlled <140/90 mm Hg**
HEDIS Reporting Year	2011	2011	2011	2011	2011	2011	2011	2011	2011	2011
Data collection methodology (administrative or hybrid)	H	H	H	H	H	H	H	H	H	H
Eligible population	505	505	505	458	505	505	505	505	505	505
Number of numerator events by administrative data in eligible population (before exclusions)	451	208	233	122	280	428	212	427	312	405
Current year's administrative rate (before exclusions)	89.31%	41.19%	46.14%	26.64%	55.45%	84.75%	41.98%	84.55%	61.78%	80.20%
Minimum required sample size (MRSS) or other sample size	505	505	505	458	505	505	505	505	505	505
Oversampling rate	0	0	0	0	0	0	0	0	0	0
Final sample size (FSS)	505	505	505	458	505	505	505	505	505	505
Number of numerator events by administrative data in FSS	451	208	233	122	280	428	212	427	312	405
Administrative rate on FSS	89.31%	41.19%	46.14%	26.64%	55.45%	84.75%	41.98%	84.55%	61.78%	80.20%
Number of original sample records excluded because of valid data errors	0	0	0	0	0	0	0	0	0	0
Number of administrative data records excluded	0	0	0	0	0	0	0	0	0	0
Number of medical data records excluded	30	30	30	30	30	30	30	30	30	30
Number of employee/dependent medical records excluded	0	0	0	0	0	0	0	0	0	0
Records added from the oversample list	0	0	0	0	0	0	0	0	0	0
Denominator	475	475	475	428	475	475	475	475	475	475
Numerator events by administrative data	440	189	222	111	276	426	212	422	294	380
Numerator events by medical records	1	0	0	0	69	0	9	9	4	2
Reported rate	92.84%	39.79%	46.74%	25.93%	72.63%	89.68%	46.53%	90.74%	62.74%	80.42%
Lower 95% confidence interval	90.42%	35.28%	42.14%	21.67%	68.52%	86.84%	41.94%	88.02%	58.28%	76.75%
Upper 95% confidence interval	95.27%	44.30%	51.33%	30.20%	76.75%	92.52%	51.12%	93.45%	67.19%	84.09%

***Note: This numerator changed from BP <130/80 to BP < 140/80 for HEDIS 2011.**

Chlamydia Screening in Women (CHL)				
Data Element	**General Measure Data**	**16-20 years**	**21-24 years**	**Total**
HEDIS Reporting Year	2011			
Data collection methodology (administrative)	A			
Eligible population		572	553	1125
Numerator events by administrative data		386	394	780
Reported rate		67.48%	71.25%	69.33%
Lower 95% confidence interval		63.56%	67.38%	66.59%
Upper 95% confidence interval		71.41%	75.11%	72.07%

Childhood Immunization Status (CIS)										
Data Element	General Measure Data	DTaP	IPV	MMR	HiB	Hep B	VZV	Pneumo-coccal Conjugate	Combo 2	Combo 3
HEDIS Reporting Year	2011									
Data collection methodology (administrative or hybrid)	A									
Eligible population	908									
Number of numerator events by admin data in eligible population (before exclusions)		NR	NR	NR	NR	NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Minimum required sample size (MRSS) or other sample Size	NR									
Oversampling rate	NR									
Final sample size	NR									
Number of numerator events by admin data in FSS		NR	NR	NR	NR	NR	NR	NR	NR	NR
Administrative rate on FSS		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Number of original records excluded because of valid data errors	NR									
Number of administrative data records excluded	NR									
Number of medical data records excluded	NR									
Number of employee/dependent medical records excluded	NR									
Records added from the oversample list	NR									
Denominator	908									
Numerator events by administrative data		827	865	849	863	865	849	823	809	798
Number of numerator events by medical records		0	0	0	0	0	0	0	0	0
Reported rate		91.08%	95.26%	93.50%	95.04%	95.26%	93.50%	90.64%	89.10%	87.89%
Lower 95% confidence interval		89.17%	93.83%	91.84%	93.58%	93.83%	91.84%	88.69%	87.01%	85.71%
Upper 95% confidence interval		92.99%	96.70%	95.16%	96.51%	96.70%	95.16%	92.59%	91.18%	90.06%

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)			
Data Element	**General Measure Data**	**LDL-C Screening**	**LDL-C level <100 mg/dL**
HEDIS Reporting Year	2011		
Data collection methodology (administrative or hybrid)	A		
Eligible population	27		
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR
Current year's administrative rate (before exclusions)		#VALUE!	#VALUE!
Minimum required sample size (MRSS) or other sample size	NR		
Oversampling rate	NR		
Final sample size (FSS)	NR		
Number of numerator events by administrative data in FSS		NR	NR
Administrative rate on FSS		#VALUE!	#VALUE!
Number of original sample records excluded because of valid data errors	NR		
Number of employee/dependent medical records excluded	NR		
Records added from the oversample list	NR		
Denominator	NR		
Numerator events by administrative data		26	13
Numerator events by medical records		NR	NR
Reported rate		#VALUE!	#VALUE!
Lower 95% confidence interval		#VALUE!	#VALUE!
Upper 95% confidence interval		#VALUE!	#VALUE!

these values are NA in the IDSS

Audit Review Table - To Be Completed by Auditor		
Measure/Data Element	**Reportable**	**Comment**
Childhood Immunization Status (cis)		
DTaP	Reportable	
IPV	Reportable	
MMR	Reportable	
HiB	Reportable	
Hepatitis B	Reportable	
VZV	Reportable	
Pneumococcal Conjugate	Reportable	
Combination #2	Reportable	
Combination #3	Reportable	
Breast Cancer Screening (bcs)	Reportable	
Chlamydia Screening in Women (chl)		
16-20 Years	Reportable	
21-24 Years	Reportable	
Total	Reportable	
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)		
LDL-C Screening Performed	NA	The denominator is <30
LDL-C Control (<100 mg/dL)	NA	The denominator is <30
Comprehensive Diabetes Care (cdc)		
Hemoglobin A1c (HbA1c) Testing	Reportable	
HbA1c Poor Control (>9.0%)	Reportable	
HbA1c Control (<8.0%)	Reportable	
HbA1c Control (<7.0%)	Reportable	
Eye Exam (Retinal) Performed	Reportable	
LDL-C Screening Performed	Reportable	
LDL-C Control (<100 mg/dL)	Reportable	
Medical Attention for Nephropathy	Reportable	
Blood Pressure Control (<140/80 mm Hg)	Reportable	
Blood Pressure Control (<140/90 mm Hg)	Reportable	
Ambulatory Care: ER Visits/1000	Reportable	
Ambulatory Care: Outpatient Visits/1000	Reportable	

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kaiser Permanente QUEST
2011

Measure			Date Received	Status
Ambulatory Care (ED visits & outpatient visit indicators)			**2/11/2011**	**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	N/A	N/A	N/A	3/4/2011
HD 2.0 - Sampling	No discrepancies found.	N/A	N/A	3/4/2011
HD 3.0 - Numerator Identification	N/A	N/A	N/A	3/4/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	3/4/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	3/4/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

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Source Code Review
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Measure	Date Received	Status
Breast Cancer Screening	**2/4/2011**	**Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	N/A	N/A	N/A	2/28/2011
HD 2.0 - Sampling	N/A	N/A	N/A	2/28/2011
HD 3.0 - Numerator Identification	Plan provided clarification for code used.	No further action required.	Plan provided codes for BCS measure and no discrepancies were found.	3/8/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	2/28/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	2/28/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kaiser Permanente QUEST
2011

Measure	Date Received	Status
Childhood Immunization Status	**2/4/2011**	**Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Missing CPT Codes 90740, 90747, 90661 and 90662 from Table CIS-A.	Please add missing CPT Codes 90740, 90747, 90661 and 90662 from Table CIS-A to CIS Immunization Id Map to CPT, and provide an updated Excel spreadsheet showing the change.	Plan clarified that the HepB vaccines they utilize do not use the referenced CPT codes.	3/14/2011
HD 2.0 - Sampling	N/A	N/A	N/A	3/4/2011
HD 3.0 - Numerator Identification	N/A	N/A	N/A	3/4/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	3/4/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	3/4/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kaiser Permanente QUEST
2011

Measure	Date Received	Status
Chlamydia Screening in Women	**2/4/2011**	**Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Source code tables to identify sexually active women during the measurement year. Source code references such tables, but no CPT, HCPCS, LOINC or ICD-CM-9 codes can be verified without sample code tables provided.	Please provide sample code tables or Excel spreadsheet with list of CPT, HCPCS, LOINC and/or ICD-CM-9 codes used.	Plan clarified that they purchase and utilize the NCQA Electronic Coding Tables and place them in their HEDIS Repository. They then link them in their source code and have provided a copy of those ECTs for all measures to HSAG for verification during the on-site review.	3/14/2011
HD 2.0 - Sampling	NA	NA	NA	2/28/2011
HD 3.0 - Numerator Identification	Source code creates tables to capture chlamydia screening given during the measurement year, and creates tables to capture exclusions. Source code references such tables, but no CPT or LOINC codes can be verified without sample code tables provided.	Please provide sample code tables or Excel spreadsheet with list of CPT and/or LOINC codes used.	Plan clarified that they purchase and utilize the NCQA Electronic Coding Tables and place them in their HEDIS Repository. They then link them in their source code and have provided a copy of those ECTs for all measures to HSAG for verification during the on-site review.	3/14/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	2/28/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	2/28/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kaiser Permanente QUEST
2011

Measure			Date Received	Status
Cholesterol Management for Patients with Cardiovascular Conditions			**2/11/2011**	**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Codes from Table CMC-C cannot be found in source code documentation. However vendor references Health Connect data used for extracting outpatient and acute inpatient data.	Please clarify how codes from Table CMC-C are used, referenced or cross-referenced with proprietary codes used in an external database.	Plan clarified that they purchase and utilize the NCQA Electronic Coding Tables and place them in their HEDIS Repository. They then link them in their source code and have provided a copy of those ECTs for all measures to HSAG for verification during the on-site review.	3/14/2011
HD 2.0 - Sampling	No sample data or rate calculations could be found in source code.	Please provide additional source code or clarification as to how the hybrid specifications of random sampling are conducted and how rates are calculated.	Plan clarified that sampling is done using the Administrative method and pointed to the roadmap included within documentation.	3/14/2011
HD 3.0 - Numerator Identification	No discrepancies found.	N/A	N/A	3/4/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	3/4/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	3/4/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kaiser Permanente QUEST
2011

Measure	Date Received	Status
Comprehensive Diabetes Care	**2/11/2011**	**Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	ICD-9-CM Procedure Code 39.43 (Table CDC-K) missing from source code: see page 22 of source code document.	Please include ICD-9-CM Procedure Code 39.43 in line of code after '39.42' in source code (See page 22 of source code document).	Plan added ICD-9-CM Procedure Code 39.43; verified to be correct.	3/14/2011
HD 2.0 - Sampling	No sample data or rate calculations could be found in source code.	Please provide additional source code or clarification as to how the hybrid specifications of random sampling are conducted and how rates are calculated.	Plan clarified they report this measure via hybrid methodology to get more complete numerator data, but because their Medicaid diabetic population is fewer than 548 members, they do not produce a random sample and instead use the entire population.	3/14/2011
HD 3.0 - Numerator Identification	1. Source code for BP Control <130/80mm Hg and <140/90mm Hg was located. Code is clear and reasonably correct. No further clarification needed for this. 2. CPT Code 83704 was added to source code (source code document page 29), but not found in Table CDC-J.	Please clarify the usage of CPT Code 83704 (source code document page 29) or remove CPT Code 83704 from line of source code and re-submit.	Plan corrected by removing CPT Code 83704 from line of source code. Verified and approved.	3/22/2011
HD 4.0 - Algorithmic compliance	N/A	N/A	N/A	3/4/2011
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	N/A	N/A	N/A	3/4/2011

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications, Volume 2 or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications, Volume 2. The health plan is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Audit Review Table			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec A			
The Auditor lock has been applied to thi			
Measure/Data Element	**Report Measure**	**Benefit Offered**	**Rotated Measure**
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		N
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Lead Screening in Children (lsc)	Y		N
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			

Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-50 Years			
Total			
Effectiveness of Care: Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		N
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	Y		
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		N
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			
Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			

45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			
12-19 Years			
Annual Dental Visit (adv)	N	N	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	Y	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Call Abandonment (cab)	Y		
Use of Services			
Frequency of Ongoing Prenatal Care (fpc)	N		
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		N
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		N
Adolescent Well-Care Visits (awc)	Y		N
Frequency of Selected Procedures (fsp)	N		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	N		
Ambulatory Care: Disabled (ambc)	N		
Ambulatory Care: Other (ambd)	N		

Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N		
Identification of Alcohol and Other Drug Services: Total (iada)	N	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	N	N	
Mental Health Utilization: Disabled (mptc)	N	N	
Mental Health Utilization: Other (mptd)	N	N	
Antibiotic Utilization: Total (abxa)	N	N	
Antibiotic Utilization: Dual Eligibles (abxb)	N	N	
Antibiotic Utilization: Disabled (abxc)	N	N	
Antibiotic Utilization: Other (abxd)	N	N	
Cost of Care			
Relative Resource Use for People With Diabetes (rdi)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Asthma (ras)	Y	Y	
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Acute Low Back Pain (rlb)	N		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			

Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
MRIs per 1,000 Member Years			
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With Hypertension (rhy)	Y		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Relative Resource Use for People With COPD (rco)	N		
Inpatient Facility: Per Member Per Month			
E & M Inpatient: Per Member Per Month			
E & M Outpatient: Per Member Per Month			
Surgery Inpatient: Per Member Per Month			
Surgery Outpatient: Per Member Per Month			
Pharmacy: Per Member Per Month			
Inpatient Facility Discharges per 1,000 Member Years			
ED Visits per 1,000 Member Years			
Health Plan Descriptive Information			
Board Certification (bcr)	N		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	N		
Enrollment by Product Line: Disabled (enpc)	N		
Enrollment by Product Line: Other (enpd)	N		
Enrollment by State (ebs)	N		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment in MCO (wop)	N		
Health Plan Stability			
Total Membership (tlm)	Y		

rea: None, Spec Proj: None); Measurement Year - 2010

s submission.

Rate	Reportable	Comment
85.06%	R	Reportable
90.51%	R	Reportable
66.91%	R	Reportable
65.94%	R	Reportable
91.08%	R	Reportable
95.26%	R	Reportable
93.50%	R	Reportable
95.04%	R	Reportable
95.26%	R	Reportable
93.50%	R	Reportable
90.64%	R	Reportable
83.04%	R	Reportable
72.25%	R	Reportable
85.35%	R	Reportable
89.10%	R	Reportable
87.89%	R	Reportable
80.40%	R	Reportable
69.49%	R	Reportable
81.61%	R	Reportable
65.20%	R	Reportable
75.77%	R	Reportable
66.30%	R	Reportable
62.44%	R	Reportable
62.75%	R	Reportable
73.26%	R	Reportable
59.18%	R	Reportable
88.23%	R	Reportable
78.41%	R	Reportable
84.41%	R	Reportable
67.48%	R	Reportable
71.25%	R	Reportable
69.33%	R	Reportable
85.21%	R	Reportable
96.32%	R	Reportable
29.58%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30

NA	R	Denominator fewer than 30
97.88%	R	Reportable
94.35%	R	Reportable
96.17%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
77.62%	R	Reportable
NA	R	Denominator fewer than 30
92.84%	R	Reportable
39.79%	R	Reportable
46.74%	R	Reportable
25.93%	R	Reportable
72.63%	R	Reportable
89.68%	R	Reportable
46.53%	R	Reportable
90.74%	R	Reportable
62.74%	R	Reportable
80.42%	R	Reportable
NA	R	Denominator fewer than 30
82.95%	R	Reportable
42.40%	R	Reportable
25.60%	R	Reportable
45.00%	R	Reportable
NA	R	Denominator fewer than 30
82.09%	R	Reportable
71.64%	R	Reportable
87.46%	R	Reportable
NA	R	Denominator fewer than 30
86.81%	R	Reportable
NA	R	Denominator fewer than 30
85.93%	R	Reportable
82.77%	R	Reportable

84.90%	R	Reportable
NA	R	Denominator fewer than 30
83.30%	R	Reportable
97.07%	R	Reportable
92.98%	R	Reportable
92.59%	R	Reportable
91.72%	R	Reportable
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
50.00%	R	Reportable
25.00%	R	Reportable
42.70%	R	Reportable
34.99%	R	Reportable
43.29%	R	Reportable
34.18%	R	Reportable
91.24%	R	Reportable
77.37%	R	Reportable
96.55%	R	Reportable
0.79%	R	Reportable
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
0.44%	R	Reportable
0.78%	R	Reportable
1.11%	R	Reportable
2.67%	R	Reportable
5.23%	R	Reportable
10.79%	R	Reportable
78.98%	R	Reportable
78.57%	R	Reportable
42.03%	R	Reportable
	NR	
	R	Reportable
	NR	
	NR	
	NR	

	R	Reportable
	NR	
	NR	
	NR	
	NR	
	NR	
	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	NR	
	NR	
	NR	
	NR	
$181.80	R	Reportable
$7.08	R	Reportable
$51.21	R	Reportable
$9.83	R	Reportable
$27.34	R	Reportable
$173.61	R	Reportable
223.26	R	Reportable
680.10	R	Reportable
$61.15	R	Reportable
$2.77	R	Reportable
$43.65	R	Reportable
$2.49	R	Reportable
$13.45	R	Reportable
$102.98	R	Reportable
104.56	R	Reportable
572.35	R	Reportable
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	

NR	NR	
NR	NR	
NR	NR	
NR	NR	
$654.95	R	Reportable
$28.78	R	Reportable
$78.00	R	Reportable
$48.28	R	Reportable
$40.66	R	Reportable
$323.18	R	Reportable
620.69	R	Reportable
1,931.03	R	Reportable
$193.97	R	Reportable
$7.41	R	Reportable
$44.62	R	Reportable
$16.41	R	Reportable
$26.20	R	Reportable
$77.14	R	Reportable
264.26	R	Reportable
570.57	R	Reportable
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
NR	NR	
	NR	
	R	Reportable
	NR	
	NR	
	NR	
	NR	
	R	Reportable
	R	Reportable
	NR	
	R	Reportable

Adult BMI Assessment (ABA)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	Measure Data
Measurement year	2010
Data collection methodology (administrative or hybrid)	A
Eligible population	3889
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of administrative data records excluded	NR
Number of medical records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	3308
Numerator events by medical records	NR
Reported rate	85.06%
Lower 95% confidence interval	83.93%
Upper 95% confidence interval	86.19%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)									
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)									
Data Element	BMI Percentile			Counseling for Nutrition			Counseling for Physical Activity		
	3-11 years	12-17 years	Total	3-11 years	12-17 years	Total	3-11 years	12-17 years	Total
Measurement year	2010			2010			2010		
Data collection methodology (administrative or hybrid)	H			H			H		
Eligible population	5746	2689	8,435	5746	2689	8,435	5746	2689	8,435
Number of numerator events by administrative data in eligible population (before exclusions)	5105	2366	7,471	3672	1534	5,206	3551	1484	5,035
Current year's administrative rate (before exclusions)	88.84%	87.99%	88.57%	63.91%	57.05%	61.72%	61.80%	55.19%	59.69%
Minimum required sample size (MRSS) or other sample size	411			411			411		
Oversampling rate	.05			.05			.05		
Final sample size	432			432			432		
Number of numerator events by administrative data in FSS	256	130	386	184	81	265	174	77	251
Administrative rate on FSS	59.26%	30.09%	89.35%	42.59%	18.75%	61.34%	40.28%	17.82%	58.10%
Number of original sample records excluded because of valid data errors	0			0			0		
Number of administrative data records excluded	0			0			0		
Number of medical records excluded	1			1			1		
Number of employee/dependent medical records excluded	0			0			0		
Records added from the oversample list	1			1			1		
Denominator	277	134	411	277	134	411	277	134	411

Numerator events by administrative data	245	123	368	177	77	254	167	73	240
Numerator events by medical records	2	2	4	13	8	21	16	15	31
Reported rate	89.17%	93.28%	90.51%	68.59%	63.43%	66.91%	66.06%	65.67%	65.94%
Lower 95% confidence interval	85.33%	88.67%	87.56%	62.95%	54.91%	62.24%	60.31%	57.26%	61.23%
Upper 95% confidence interval	93.01%	97.89%	93.47%	74.24%	71.96%	71.58%	71.82%	74.08%	70.64%

Childhood Immunization Status (CIS)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Data Element	**General Measure Data**	**DTaP**	**IPV**	**MMR**	**HiB**	**Hepatitis B**	**VZV**	**Pneumo-coccal Conjugate**
Measurement year	2010							
Data collection methodology (administrative or hybrid)	A							
Eligible population	908							
Number of numerator events by admin data in eligible population (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Minimum required sample size (MRSS) or other sample Size	NR							
Oversampling rate	NR							
Final sample size	NR							
Number of numerator events by admin data in FSS		NR	NR	NR	NR	NR	NR	NR
Administrative rate on FSS		NR	NR	NR	NR	NR	NR	NR
Number of original records excluded because of valid data errors	NR							
Number of administrative data records excluded	NR							
Number of medical data records excluded	NR							
Number of employee/dependent medical records excluded	NR							
Records added from the oversample list	NR							
Denominator	NR							
Numerator events by administrative data		827	865	849	863	865	849	823

Number of numerator events by medical records		NR	NR	NR	NR	NR	NR	NR
Reported rate		91.08%	95.26%	93.50%	95.04%	95.26%	93.50%	90.64%
Lower 95% confidence interval		89.17%	93.83%	91.84%	93.58%	93.83%	91.84%	88.69%
Upper 95% confidence interval		92.99%	96.70%	95.16%	96.51%	96.70%	95.16%	92.59%

Hepatitis A	Rotavirus	Influenza	Combination 2	Combination 3	Combination 4	Combination 5	Combination 6	Combination 7	Combination 8	Combination 9	Combination 10
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
754	656	775	809	798	730	631	741	592	688	602	567

NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
83.04%	72.25%	85.35%	89.10%	87.89%	80.40%	69.49%	81.61%	65.20%	75.77%	66.30%	62.44%
80.54%	69.28%	83.00%	87.01%	85.71%	77.76%	66.44%	79.03%	62.04%	72.93%	63.17%	59.24%
85.54%	75.21%	87.71%	91.18%	90.06%	83.03%	72.54%	84.18%	68.35%	78.61%	69.43%	65.65%

Immunizations for Adolescents (IMA)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Data Element	**General Measure Data**	**Meningococcal**	**Tdap/Td**	**Combination 1**
Measurement year	2010			
Data collection methodology (administrative or hybrid)	A			
Eligible population	561			
Number of numerator events by admin data in eligible population (before exclusions)		NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR
Minimum required sample size (MRSS) or other sample Size	NR			
Oversampling rate	NR			
Final sample size	NR			
Number of numerator events by admin data in FSS		NR	NR	NR
Administrative rate on FSS		NR	NR	NR
Number of original records excluded because of valid data errors	NR			
Number of administrative data records excluded	NR			
Number of medical data records excluded	NR			
Number of employee/dependent medical records excluded	NR			
Records added from the oversample	NR			
Denominator	NR			
Numerator events by administrative data		352	411	332
Number of numerator events by medical records		NR	NR	NR
Reported rate		62.75%	73.26%	59.18%
Lower 95% confidence interval		58.66%	69.51%	55.02%
Upper 95% confidence interval		66.84%	77.01%	63.34%

Lead Screening in Children (LSC)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Lead Screening in Children	
Data Elements which do not apply to the selected data collection methodology will not appear	General Measure Data
Measurement year	2010
Data collection methodology (administrative or hybrid)	A
Eligible population	909
Number of numerator events by admin data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of administrative data records excluded	NR
Number of medical data records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	802
Numerator events by medical records	NR
Reported rate	88.23%
Lower 95% confidence interval	86.08%
Upper 95% confidence interval	90.38%

Breast Cancer Screening (BCS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**General Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	690
Numerator events by administrative data	541
Reported rate	78.41%
Lower 95% confidence interval	75.26%
Upper 95% confidence interval	81.55%

Cervical Cancer Screening (CCS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative or hybrid)	A
Eligible population	2873
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of administrative data records excluded	NR
Number of medical data records excluded	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	2425
Numerator events by medical records	NR
Reported rate	84.41%
Lower 95% confidence interval	83.06%
Upper 95% confidence interval	85.75%

Chlamydia Screening in Women (CHL)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid,				
Data Element	**General Measure Data**	**16-20 years**	**21-24 years**	**Total**
Measurement year	2010			
Data collection methodology (administrative)	A			
Eligible population		572	553	1,125
Numerator events by administrative data		386	394	780
Reported rate		67.48%	71.25%	69.33%
Lower 95% confidence interval		63.56%	67.38%	66.59%
Upper 95% confidence interval		71.41%	75.11%	72.07%

Appropriate Testing for Children with Pharyngitis (CWP)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None,	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	338
Numerator events by administrative data	288
Reported rate	85.21%
Lower 95% confidence interval	81.27%
Upper 95% confidence interval	89.14%

Appropriate Treatment for Children With URI (URI)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	1061
Numerator events by administrative data	39
Reported rate	96.32%
Lower 95% confidence interval	95.14%
Upper 95% confidence interval	97.50%

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	71
Total numerator events by administrative data	50
Reported rate	29.58%
Lower 95% confidence interval	18.26%
Upper 95% confidence interval	40.90%

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	10
Numerator events by administrative data	5
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Pharmacotherapy Management of COPD Exacerbation (PCE)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Pharmacotherapy Management of COPD Exacerbation			
Data Elements	**Measure Data**	**Systemic corticosteroid**	**Bronchodilator**
Measurement year	2010		
Data collection methodology (administrative)	A		
Eligible population	1		
Numerator events by administrative data		1	0
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Use of Appropriate Medications for People With Asthma (ASM)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Data Element	**General Measure**	**5-11 years**	**12-50 years**	**Total**
Measurement year	2010			
Data collection methodology (administrative)	A			
Eligible population		189	177	366
Numerator events by administrative data		185	167	352
Reported rate		97.88%	94.35%	96.17%
Lower 95% confidence interval		95.57%	90.67%	94.07%
Upper 95% confidence interval		100.00%	98.03%	98.28%

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019,			
Data Element	General Measure Data	LDL-C Screening	LDL-C level <100 mg/dL
Measurement year	2010		
Data collection methodology (administrative or hybrid)	A		
Eligible population	27		
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR
Current year's administrative rate (before exclusions)		NR	NR
Minimum required sample size (MRSS) or other sample size	NR		
Oversampling rate	NR		
Final sample size (FSS)	NR		
Number of numerator events by administrative data in FSS		NR	NR
Administrative rate on FSS		NR	NR
Number of original sample records excluded because of valid data errors	NR		
Number of employee/dependent medical records excluded	NR		
Records added from the oversample list	NR		
Denominator	NR		
Numerator events by administrative data		26	13
Numerator events by medical records		NR	NR
Reported rate		NA	NA
Lower 95% confidence interval		NA	NA
Upper 95% confidence interval		NA	NA

Controlling High Blood Pressure (CBP)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	General Measure Data
Measurement year	2010
Data collection methodology (hybrid)	H
Eligible population	413
Number of numerator events by administrative data in eligible population (before exclusions)	0
Current year's administrative rate (before exclusions)	0.00%
Minimum required sample size (MRSS) or other sample size	411
Oversampling rate	.05
Final sample size (FSS)	413
Number of numerator events by administrative data in FSS	0
Administrative rate on FSS	0.00%
Number of original sample records excluded because of valid data errors	0
Number of records excluded because of false positive diagnoses	0
Number of administrative data records excluded	0
Number of medical data records excluded	0
Number of employee/dependent medical records excluded	0
Records added from the oversample list	0
Denominator	411
Numerator events by administrative data	0
Numerator events by medical records	319
Reported rate	77.62%
Lower 95% confidence interval	73.46%
Upper 95% confidence interval	81.77%

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	3
Numerator events by administrative data	2
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Comprehensive Diabetes Care (CDC)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec				
Data Element	**HbA1c Testing**	**HbA1c Poor Control (>9.0%)**	**HbA1c Control (<8.0%)**	**HbA1c Control (<7.0%) for a Selected Population**
Measurement year	2010	2010	2010	2010
Data collection methodology (administrative or hybrid)	H	H	H	H
Eligible population	505	505	505	458
Number of numerator events by administrative data in eligible population (before optional exclusions)	451	208	233	122
Current year's administrative rate (before optional exclusions)	89.31%	41.19%	46.14%	26.64%
Minimum required sample size (MRSS) or other sample size	505	505	505	458
Oversampling rate	0	0	0	0
Final sample size (FSS)	505	505	505	458
Number of numerator events by administrative data in FSS	451	208	233	122
Administrative rate on FSS	89.31%	41.19%	46.14%	26.64%
Number of original sample records excluded because of valid data errors	0	0	0	0
Number of optional administrative data records excluded	0	0	0	0
Number of optional medical data records excluded	30	30	30	30
Number of HbA1c <7 required medical records excluded				0
Number of HbA1c <7 required administrative data records excluded				47
Number of employee/dependent medical records excluded	0	0	0	0
Records added from the oversample list	0	0	0	0
Denominator	475	475	475	428
Numerator events by administrative data	440	189	222	111
Numerator events by medical records	1	0	0	0
Reported rate	92.84%	39.79%	46.74%	25.93%
Lower 95% confidence interval	90.42%	35.28%	42.14%	21.67%
Upper 95% confidence interval	95.27%	44.30%	51.33%	30.20%

Area: None, Spec Proj: None)					
Eye Exam	**LDL-C Screening**	**LDL-C Level <100 mg/dL**	**Medical Attention for Nephropathy**	**Blood Pressure Controlled <140/80 mm Hg**	**Blood Pressure Controlled <140/90 mm Hg**
2010	2010	2010	2010	2010	2010
H	H	H	H	H	H
505	505	505	505	505	505
280	428	212	427	312	405
55.45%	84.75%	41.98%	84.55%	61.78%	80.20%
505	505	505	505	505	505
0	0	0	0	0	0
505	505	505	505	505	505
280	428	212	427	312	405
55.45%	84.75%	41.98%	84.55%	61.78%	80.20%
0	0	0	0	0	0
0	0	0	0	0	0
30	30	30	30	30	30
0	0	0	0	0	0
0	0	0	0	0	0
475	475	475	475	475	475
276	426	212	422	294	380
69	0	9	9	4	2
72.63%	89.68%	46.53%	90.74%	62.74%	80.42%
68.52%	86.84%	41.94%	88.02%	58.28%	76.75%
76.75%	92.52%	51.12%	93.45%	67.19%	84.09%

Disease Modifying Anti-Rheumatic Drug therapy in Rheumatoid Arthritis (ART)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None,	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	11
Numerator events by administrative data	10
Reported rate	NA
Lower 95% confidence interval	NA
Upper 95% confidence interval	NA

Use of Imaging Studies for Low Back Pain (LBP)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	258
Numerator events by administrative data	44
Reported rate	82.95%
Lower 95% confidence Interval	78.16%
Upper 95% confidence Interval	87.73%

Antidepressant Medication Management (AMM)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**Effective Acute Phase Treatment**	**Effective Continuation Phase Treatment**
Measurement year	2010		
Data collection methodology (administrative)	A		
Eligible population	125		
Numerator events by administrative data		53	32
Reported rate		42.40%	25.60%
Lower 95% confidence interval		33.34%	17.55%
Upper 95% confidence interval		51.46%	33.65%

Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**Initiation Phase**	**Continuation and Maintenance Phase**
Measurement year	2010		
Data collection methodology (administrative)	A		
Eligible population		60	5
Numerator events by administrative data		27	1
Reported rate		45.00%	NA
Lower 95% confidence interval		31.58%	NA
Upper 95% confidence interval		58.42%	NA

Follow-Up After Hospitalization for Mental Illness (FUH)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Data Element	**General Measure Data**	**30-day follow-up**	**7-day follow-up**
Measurement year	2010		
Data collection methodology (administrative)	A		
Eligible population	67		
Numerator events by administrative data		55	48
Reported rate		82.09%	71.64%
Lower 95% confidence interval		72.16%	60.10%
Upper 95% confidence interval		92.02%	83.18%

Annual Monitoring for Patients on Persistent Medications (MPM)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)						
Data Element	**General Measure Data**	**ACE Inhibitors or ARBs**	**Digoxin**	**Diuretics**	**Anti-convulsants**	**Total**
Measurement year	2010					
Data collection methodology (administrative)	A					
Eligible population		319	8	182	24	533
Numerator events by administrative data		279	7	158	14	458
Reported rate		87.46%	NA	86.81%	NA	85.93%
Lower 95% confidence interval		83.67%	NA	81.62%	NA	82.88%
Upper 95% confidence interval		91.25%	NA	92.00%	NA	88.97%

Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**20-44 years**	**45-64 years**	**65+ years**	**Total**
Measurement year	2010				
Data collection methodology (administrative)	A				
Eligible population		3946	1318	0	5,264
Numerator events by administrative data		3266	1119	0	4,385
Reported rate		82.77%	84.90%	NA	83.30%
Lower 95% confidence interval		81.58%	82.93%	NA	82.28%
Upper 95% confidence interval		83.96%	86.87%	NA	84.32%

Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Data Element	**General Measure Data**	**12-24 months**	**25 months - 6 years**	**7-11 years**	**12-19 years**
Measurement year	2010				
Data collection methodology (administrative)	A				
Eligible population		1023	4258	3037	3649
Numerator events by administrative data		993	3959	2812	3347
Reported rate		97.07%	92.98%	92.59%	91.72%
Lower 95% confidence interval		95.98%	92.20%	91.64%	90.82%
Upper 95% confidence interval		98.15%	93.76%	93.54%	92.63%

Annual Dental Visit (ADV)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Data Element	**Measure Data**	**2-3 Years**	**4-6 Years**	**7-10 Years**	**11-14 Years**	**15-18 Years**	**19-21 Years**	**Total**
Measurement year	NR							
Data collection methodology (administrative)	NR							
Eligible population		NR	NR	NR	NR	NR	NR	NR
Numerator events by administrative data		NR	NR	NR	NR	NR	NR	NR
Reported rate		NR	NR	NR	NR	NR	NR	NR
Lower 95% confidence interval		NR	NR	NR	NR	NR	NR	NR
Upper 95% confidence interval		NR	NR	NR	NR	NR	NR	NR

Initiation and Engagement of AOD Dependence Treatment (IET)							
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)							
Data Elements	General Measure Data	13-17 years		18+ years		Total	
		Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
Measurement year	2010						
Data collection methodology (administrative)	A						
Eligible population		32		363		395	
Numerator events by administrative data		16	8	155	127	171	135
Reported rate		50.00%	25.00%	42.70%	34.99%	43.29%	34.18%
Lower 95% confidence interval		31.11%	8.43%	37.47%	29.94%	38.28%	29.37%
Upper 95% confidence interval		68.89%	41.57%	47.93%	40.03%	48.30%	38.98%

Prenatal and Postpartum Care (PPC)		
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124,		
Data Element	Timeliness of Prenatal Care	Postpartum Care
Measurement year	2010	2010
Data collection methodology (administrative or hybrid)	H	H
Eligible population	566	566
Number of numerator events by administrative data in eligible population (before exclusions)	449	380
Current year's administrative rate (before exclusions)	79.33%	67.14%
Minimum required sample size (MRSS) or other sample size	411	411
Oversampling rate	.05	.05
Final sample size (FSS)	432	432
Number of numerator events by administrative data in FSS	341	291
Administrative rate on FSS	78.94%	67.36%
Number of original sample records excluded because of valid data errors	0	0
Number of employee/dependent medical records excluded	0	0
Records added from the oversample list	0	0
Denominator	411	411
Numerator events by administrative data	323	278
Numerator events by medical records	52	40
Reported rate	91.24%	77.37%
Lower 95% confidence interval	88.39%	73.21%
Upper 95% confidence interval	94.10%	81.54%

Call Answer Timeliness (CAT)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	187809
Numerator events by administrative data	181336
Reported rate	96.55%
Lower 95% confidence interval	96.47%
Upper 95% confidence interval	96.64%

Call Abandonment (CAB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative)	A
Eligible population	187809
Numerator events by administrative data	1475
Reported rate	0.79%
Lower 95% confidence interval	0.75%
Upper 95% confidence interval	0.83%

Frequency of Ongoing Prenatal Care (FPC)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj:						
Data Element	**General Measure Data**	**<21 Percent**	**21-40 Percent**	**41-60 Percent**	**61-80 Percent**	**81+ Percent**
Measurement year	NR					
Data collection methodology (administrative or hybrid)	NR					
Eligible population	NR					
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR	NR	NR
Minimum required sample size (MRSS) or other sample size	NR					
Oversampling rate	NR					
Final sample size (FSS)	NR					
Number of numerator events by administrative data in FSS		NR	NR	NR	NR	NR
Administrative rate on FSS		NR	NR	NR	NR	NR
Number of original sample records excluded because of valid data errors	NR					
Number of employee/dependent medical records excluded	NR					
Records added from the oversample list	NR					
Denominator	NR					
Numerator events by administrative data		NR	NR	NR	NR	NR
Numerator events by medical records		NR	NR	NR	NR	NR
Reported rate		NR	NR	NR	NR	NR
Lower 95% confidence interval		NR	NR	NR	NR	NR
Upper 95% confidence interval		NR	NR	NR	NR	NR

Well-Child Visits in the First 15 Months of Life (W15)								
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)								
Data Element	**Measure Data**	**0 visits**	**1 visit**	**2 visits**	**3 visits**	**4 visits**	**5 visits**	**6 or more visits**
Measurement year	2010							
Data collection methodology (administrative or hybrid)	A							
Eligible population	899							
Number of numerator events by administrative data in eligible population (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Current year's administrative rate (before exclusions)		NR	NR	NR	NR	NR	NR	NR
Minimum required sample size (MRSS) or other sample size	NR							
Oversampling rate	NR							
Final sample size (FSS)	NR							
Number of numerator events by administrative data in FSS		NR	NR	NR	NR	NR	NR	NR
Administrative rate on FSS		NR	NR	NR	NR	NR	NR	NR
Number of original sample records excluded because of valid data errors	NR							
Number of employee/dependent medical records excluded	NR							
Records added from the oversample list	NR							
Denominator	NR							
Numerator events by administrative data		4	7	10	24	47	97	710
Numerator events by medical records		NR	NR	NR	NR	NR	NR	NR
Reported rate		0.44%	0.78%	1.11%	2.67%	5.23%	10.79%	78.98%
Lower 95% confidence interval		0.00%	0.15%	0.37%	1.56%	3.72%	8.71%	76.26%
Upper 95% confidence interval		0.94%	1.41%	1.85%	3.78%	6.74%	12.87%	81.70%

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative or hybrid)	A
Eligible population	3402
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	2673
Numerator events by medical records	NR
Reported rate	78.57%
Lower 95% confidence interval	77.18%
Upper 95% confidence interval	79.96%

Adolescent Well-Care Visits (AWC)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Data Element	**Measure Data**
Measurement year	2010
Data collection methodology (administrative or hybrid)	A
Eligible population	4701
Number of numerator events by administrative data in eligible population (before exclusions)	NR
Current year's administrative rate (before exclusions)	NR
Minimum required sample size (MRSS) or other sample size	NR
Oversampling rate	NR
Final sample size (FSS)	NR
Number of numerator events by administrative data in FSS	NR
Administrative rate on FSS	NR
Number of original sample records excluded because of valid data errors	NR
Number of employee/dependent medical records excluded	NR
Records added from the oversample list	NR
Denominator	NR
Numerator events by administrative data	1976
Numerator events by medical records	NR
Reported rate	42.03%
Lower 95% confidence interval	40.61%
Upper 95% confidence interval	43.46%

Frequency of Selected Procedures (FSP)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Age	**Male**	**Female**	**Total**	
0-4			NR	
0-9			NR	
5-19			NR	
10-19			NR	
15-44		NR		
20-44	NR	NR		
30-64	NR			
45-64	NR	NR		
Procedure	**Age**	**Sex**	**Number of Procedures**	**Procedures / 1,000 Member Months**
Bariatric weight loss surgery	**0-19**	**Male & Female**	NR	NR
	20-44		NR	NR
	45-64		NR	NR
Tonsillectomy	**0-9**	**Male & Female**	NR	NR
	10-19		NR	NR
Hysterectomy, Abdominal	**15-44**	**Female**	NR	NR
	45-64		NR	NR
Hysterectomy,Vaginal	**15-44**	**Female**	NR	NR
	45-64		NR	NR
Cholecystectomy,Open	**30-64**	**Male**	NR	NR
	15-44	**Female**	NR	NR
	45-64		NR	NR
Cholecystectomy,Closed	**30-64**	**Male**	NR	NR
	15-44	**Female**	NR	NR
	45-64		NR	NR
Back Surgery	**20-44**	**Male**	NR	NR
		Female	NR	NR
	45-64	**Male**	NR	NR
		Female	NR	NR
Mastectomy	**15-44**	**Female**	NR	NR
	45-64		NR	NR
Lumpectomy	**15-44**	**Female**	NR	NR
	45-64		NR	NR

Ambulatory Care: Total (AMBA)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Age	Member Months			
<1	13,141			
1-9	102,045			
10-19	76,154			
20-44	68,448			
45-64	20,746			
65-74	0			
75-84	0			
85+	0			
Unknown	0			
Total	280,534			
Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member	Visits	Visits/ 1,000 Member
<1	11256	856.56	486	36.98
1-9	28796	282.19	1877	18.39
10-19	15891	208.67	1083	14.22
20-44	21068	307.80	2210	32.29
45-64	9033	435.41	612	29.50
65-74	0	NA	0	NA
75-84	0	NA	0	NA
85+	0	NA	0	NA
Unknown	0		0	
Total	86,044	306.72	6,268	22.34

Ambulatory Care: Dual Eligibles (AMBB)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Age	Member Months			
<1	NR			
1-9	NR			
10-19	NR			
20-44	NR			
45-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member	Visits	Visits/ 1,000 Member
<1	NR	NR	NR	NR
1-9	NR	NR	NR	NR
10-19	NR	NR	NR	NR
20-44	NR	NR	NR	NR
45-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Ambulatory Care: Disabled (AMBC)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Age	Member Months			
<1	NR			
1-9	NR			
10-19	NR			
20-44	NR			
45-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member	Visits	Visits/ 1,000 Member
<1	NR	NR	NR	NR
1-9	NR	NR	NR	NR
10-19	NR	NR	NR	NR
20-44	NR	NR	NR	NR
45-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Ambulatory Care: Other (AMBD)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)				
Age	Member Months			
<1	NR			
1-9	NR			
10-19	NR			
20-44	NR			
45-64	NR			
65-74	NR			
75-84	NR			
85+	NR			
Unknown	NR			
Total	NR			
Age	Outpatient Visits		ED Visits	
	Visits	Visits/ 1,000 Member	Visits	Visits/ 1,000 Member
<1	NR	NR	NR	NR
1-9	NR	NR	NR	NR
10-19	NR	NR	NR	NR
20-44	NR	NR	NR	NR
45-64	NR	NR	NR	NR
65-74	NR	NR	NR	NR
75-84	NR	NR	NR	NR
85+	NR	NR	NR	NR
Unknown	NR		NR	
Total	NR	NR	NR	NR

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Age	**Member Months**				
<1	13,141				
1-9	102,045				
10-19	76,154				
20-44	68,448				
45-64	20,746				
65-74	0				
75-84	0				
85+	0				
Unknown	0				
Total	280,534				
Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	62	4.72	278	21.16	4.48
1-9	77	0.75	212	2.08	2.75
10-19	182	2.39	483	6.34	2.65
20-44	891	13.02	2314	33.81	2.60
45-64	179	8.63	948	45.70	5.30
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	1,391	4.96	4,235	15.10	3.04
Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	50	3.80	177	13.47	3.54
1-9	121	1.19	422	4.14	3.49
10-19	113	1.48	529	6.95	4.68
20-44	42	0.61	120	1.75	2.86
45-64	53	2.55	120	5.78	2.26
65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	379	1.35	1,368	4.88	3.61
Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	12	0.91	101	7.69	8.42
1-9	77	0.75	327	3.20	4.25
10-19	64	0.84	415	5.45	6.48
20-44	22	0.32	68	0.99	3.09
45-64	24	1.16	92	4.43	3.83

65-74	0	NA	0	NA	NA
75-84	0	NA	0	NA	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	199	0.71	1,003	3.58	5.04
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	118	1.55	295	3.87	2.50
20-44	693	10.12	1565	22.86	2.26
45-64	2	0.10	4	0.19	2.00
Unknown	0		0		NA
Total	813	4.92	1,864	11.27	2.29

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (IPUB)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	**Member Months**
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR

65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Disabled (IPUC)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)					
Age	**Member Months**				
<1	NR				
1-9	NR				
10-19	NR				
20-44	NR				
45-64	NR				
65-74	NR				
75-84	NR				
85+	NR				
Unknown	NR				
Total	NR				
Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR

65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Other (IPUD)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Age	**Member Months**
<1	NR
1-9	NR
10-19	NR
20-44	NR
45-64	NR
65-74	NR
75-84	NR
85+	NR
Unknown	NR
Total	NR

Total Inpatient					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Medicine					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	NR	NR	NR	NR	NR
1-9	NR	NR	NR	NR	NR
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR

65-74	NR	NR	NR	NR	NR
75-84	NR	NR	NR	NR	NR
85+	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	NR	NR	NR	NR	NR
20-44	NR	NR	NR	NR	NR
45-64	NR	NR	NR	NR	NR
Unknown	NR		NR		NR
Total	NR	NR	NR	NR	NR

***The maternity category is calculated using member months for members 10-64 years.**

Identification of Alcohol and Other Drug Services: Total (IADA)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	**Member Months (Any)**			**Member Months (In**	
	Male	**Female**	**Total**	**Male**	**Female**
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	**Sex**	**Any Services**		**Inpatient**	
		Number	**Percent**	**Number**	**Percent**
0-12	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-24	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
25-34	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
35-64	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

one, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Identification of Alcohol and Other Drug Services: Dual Eligibles (IADB)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

one, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Identification of Alcohol and Other Drug Services: Disabled (IADC)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

lone, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Identification of Alcohol and Other Drug Services: Other (IADD)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: Nc					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-24	NR	NR	NR	NR	NR
25-34	NR	NR	NR	NR	NR
35-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-24	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
25-34	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
35-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

one, Spec Proj: None)

patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR

Mental Health Utilization: Total (MPTA)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	73138	68021	141,159	73138	68021
13-17	19401	19574	38,975	19401	19574
18-64	35236	65164	100,400	35236	65164
65+	0	0	0	0	0
Unknown	0	0	0	0	0
Total	127,775	152,759	280,534	127,775	152,759

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	249	4.09%	3	0.05%
	F	122	2.15%	2	0.04%
	Total	371	3.15%	5	0.04%
13-17	M	111	6.87%	6	0.37%
	F	138	8.46%	20	1.23%
	Total	249	7.67%	26	0.80%
18-64	M	269	9.16%	35	1.19%
	F	607	11.18%	61	1.12%
	Total	876	10.47%	96	1.15%
65+	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Unknown	M	0	NA	0	NA
	F	0	NA	0	NA
	Total	0	NA	0	NA
Total	M	629	5.91%	44	0.41%
	F	867	6.81%	83	0.65%
	Total	1,496	6.40%	127	0.54%

one, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
141,159	73138	68021	141,159	73138	68021	141,159
38,975	19401	19574	38,975	19401	19574	38,975
100,400	35236	65164	100,400	35236	65164	100,400
0	0	0	0	0	0	0
0	0	0	0	0	0	0
280,534	127,775	152,759	280,534	127,775	152,759	280,534

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
0	0.00%	248	4.07%
0	0.00%	121	2.13%
0	0.00%	369	3.14%
1	0.06%	108	6.68%
0	0.00%	133	8.15%
1	0.03%	241	7.42%
1	0.03%	254	8.65%
1	0.02%	589	10.85%
2	0.02%	843	10.08%
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
0	NA	0	NA
2	0.02%	610	5.73%
1	0.01%	843	6.62%
3	0.01%	1,453	6.22%

Mental Health Utilization: Dual Eligibles (MPTB)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

lone, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR

Mental Health Utilization: Disabled (MPTC)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

one, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR
NR	NR	NR	NR

Mental Health Utilization: Other (MPTD)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:					
Age	Member Months (Any)			Member Months (In	
	Male	Female	Total	Male	Female
0-12	NR	NR	NR	NR	NR
13-17	NR	NR	NR	NR	NR
18-64	NR	NR	NR	NR	NR
65+	NR	NR	NR	NR	NR
Unknown	NR	NR	NR	NR	NR
Total	NR	NR	NR	NR	NR

Age	Sex	Any Services		Inpatient	
		Number	Percent	Number	Percent
0-12	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
13-17	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
18-64	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65+	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Unknown	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	M	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

None, Spec Proj: None)						
patient)	Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
Number	Percent	Number	Percent
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR
NR	NR	NR	NR
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NR	NR	NR	NR
NR	NR	NR	NR

Antibiotic Utilization: Total (ABXA)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Pharmacy Benefit Member Months

Age	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

								Antibiotics of Concern Utilization
Age	**Sex**	**Total Quinolone Scrips**	**Average Scrips PMPY for Quinolones**	**Total Cephalo-sporin 2nd-4th Generation Scrips**	**Average Scrips PMPY for Cephalo-sporins 2nd-4th Generation**	**Total Azithromycin and Clarithro-mycin Scrips**	**Average Scrips PMPY for Azithromycins and Clarithro-mycins**	**Total Amoxicillin / Clavulanate Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

All Other Antibiotics Utilizati								
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Amino-glycoside Scrips**	**Average Scrips PMPY for Amino-glycosides**	**Total 1st Generation Cephalo-sporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalo-**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR

on

Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Antibiotic Utilization: Dual Eligibles (ABXB)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

on

Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Antibiotic Utilization: Disabled (ABXC)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR

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Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Antibiotic Utilization: Other (ABXD)

Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)

Member Months

Age	Member Months		
	Male	Female	Total
0-9	NR	NR	NR
10-17	NR	NR	NR
18-34	NR	NR	NR
35-49	NR	NR	NR
50-64	NR	NR	NR
65-74	NR	NR	NR
75-84	NR	NR	NR
85+	NR	NR	NR
Unknown	NR	NR	NR
Total	NR	NR	NR

Antibiotic Utilization

Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Anitbiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic
0-9	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	M	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

50-64	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Antibiotics of Concern Utilization

Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin / Clavulanate Scrips
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
35-49	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR

	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
								All Other Antibiotics Utilizati
Age	**Sex**	**Total Absorbable Sulfonamide Scrips**	**Average Scrips PMPY for Absorbable Sulfonami**	**Total Aminoglycoside Scrips**	**Average Scrips PMPY for Aminoglycosides**	**Total 1st Generation Cephalosporin Scrips**	**Average Scrips PMPY for 1st Generation Cephalosp**	**Total Lincosamide Scrips**
0-9	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
10-17	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
18-34	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
	M	NR	NR	NR	NR	NR	NR	NR

35-49	**F**	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
50-64	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
75-84	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
85+	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Unknown	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR	NR	NR	NR
	F	NR	NR	NR	NR	NR	NR	NR
	Total	NR	NR	NR	NR	NR	NR	NR

Average Scrips PMPY for Amoxicillin / Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
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NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

on

Average Scrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrips	Average Scrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrips	Average Scrips PMPY for Penicillins	Total Tetracycline Scrips	Average Scrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrips	Average Scrips PMPY for Misc. Antibiotics
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR

Relative Resource Use for People With Diabetes (RDI)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: N	

Eligible Population	
Category	Eligible Population
Total	494
Exclusions (required)	11
Type 1 with Comorbidity	11
Type 2 with Comorbidity	271
Type 1 without Comorbidity	24
Type 2 without Comorbidity	188

Medical Benefit Mem

Age	Member Months (Diabetes Type 1 with Comorbidity)			Member Months (Diabe without Comorbi	
	Male	Female	Total	Male	Female
18-44*	12	60	72	86	179
45-54	29	12	41	0	0
55-64	0	12	12	12	0
65-75	0	0	0	0	0
Total	41	84	125	98	179

* Include any Member Months that occur at age 17 in the 18-44 category.

Pharmacy Benefit Mer

Age	Member Months (Diabetes Type 1 with Comorbidity)			Member Months (Diabe without Comorbi	
	Male	Female	Total	Male	Female
18-44	12	60	72	86	179
45-54	29	12	41	0	0
55-64	0	12	12	12	0
65-75	0	0	0	0	0
Total	41	84	125	98	179

Diabetes Type 1 with Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	7575	125	1666	24
	F	3477	0	8118	0
	Total	$11,052.00	$125.00	$9,784.00	$24.00
45-54	M	82044	2655	4846	5490
	F	66848	2292	2500	515
	Total	$148,892.0	$4,947.00	$7,346.00	$6,005.00
55-64	M	0	0	0	0
	F	0	0	308	0
	Total	$0.00	$0.00	$308.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$89,619.00	$2,780.00	$6,512.00	$5,514.00
	F	$70,325.00	$2,292.00	$10,926.00	$515.00
	Total	$159,944.0	$5,072.00	$17,438.00	$6,029.00

Diabetes Type 1 without Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	10882	1092	1545	0
	F	57820	1563	6905	408
	Total	$68,702.00	$2,655.00	$8,450.00	$408.00
45-54	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
55-64	M	0	0	747	0
	F	0	0	0	0
	Total	$0.00	$0.00	$747.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$10,882.00	$1,092.00	$2,292.00	$0.00
	F	$57,820.00	$1,563.00	$6,905.00	$408.00
	Total	$68,702.00	$2,655.00	$9,197.00	$408.00

Diabetes Type 2 with Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	173948	7004	32413	10317
	F	94640	4943	44491	3932
	Total	$268,588.0	$11,947.00	$76,904.00	$14,249.00
45-54	M	105026	4492	30175	6967
	F	149311	6431	38059	4983
	Total	$254,337.0	$10,923.00	$68,234.00	$11,950.00
55-64	M	98666	2616	22990	18237
	F	45732	2662	25679	1857
	Total	$144,398.0	$5,278.00	$48,669.00	$20,094.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$377,640.0	$14,112.00	$85,578.00	$35,521.00
	F	$289,683.0	$14,036.00	$108,229.0	$10,772.00
	Total	$667,323.0	$28,148.00	$193,807.0	$46,293.00

Diabetes Type 2 without Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	43122	1215	12602	1105
	F	111035	3632	39771	3232
	Total	$154,157.0	$4,847.00	$52,373.00	$4,337.00
45-54	M	5198	402	6764	16
	F	0	0	11262	0
	Total	$5,198.00	$402.00	$18,026.00	$16.00

55-64	M	0	00	2955	0
	F	0	0	3469	0
	Total	$0.00	$0.00	$6,424.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$48,320.00	$1,617.00	$22,321.00	$1,121.00
	F	$111,035.0	$3,632.00	$54,502.00	$3,232.00
	Total	$159,355.0	$5,249.00	$76,823.00	$4,353.00

Diabetes Totals

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility - PMPM	E & M - Inpatient - PMPM	E & M - Outpatient - PMPM	Surgery and Procedure - Inpatient - PMPM
18-44	M	$221.57	$8.88	$45.37	$10.77
	F	$128.60	$4.88	$47.83	$3.65
	Total	$160.08	$6.24	$46.99	$6.06
45-54	M	$260.17	$10.22	$56.54	$16.88
	F	$279.64	$11.28	$67.04	$7.11
	Total	$270.12	$10.76	$61.91	$11.89
55-64	M	$184.08	$4.88	$49.80	$34.02
	F	$74.00	$4.31	$47.66	$3.00
	Total	$125.13	$4.57	$48.66	$17.41
65-75	M	NA	NA	NA	NA
	F	NA	NA	NA	NA
	Total	NA	NA	NA	NA
Total	M	$225.18	$8.38	$49.92	$18.03
	F	$152.54	$6.21	$52.08	$4.31
	Total	$181.80	$7.08	$51.21	$9.83

one, Spec Proj: None)

ber Months						
tes Type 1 dity)	Member Months (Diabetes Type 2 with Comorbidity)			Member Months (Diabetes Type 2 without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
265	558	725	1,283	407	1112	1,519
0	495	504	999	215	257	472
12	428	475	903	96	131	227
0	0	0	0	0	0	0
277	1,481	1,704	3,185	718	1,500	2,218

nber Months						
tes Type 1 dity)	Member Months (Diabetes Type 2 with Comorbidity)			Member Months (Diabetes Type 2 without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
265	558	724	1,282	407	1112	1,519
0	495	504	999	215	257	472
12	428	475	903	96	131	227
0	0	0	0	0	0	0
277	1,481	1,703	3,184	718	1,500	2,218

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
204	3103	2	12
3748	22130	1	6
$3,952.00	$25,233.00	3	18
4241	12366	2	2
596	1385	9	8
$4,837.00	$13,751.00	11	10
0	0	0	0
16	4543	0	0
$16.00	$4,543.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$4,445.00	$15,469.00	4	14
$4,360.00	$28,058.00	10	14
$8,805.00	$43,527.00	14	28

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
231	25092	2	2
1632	54416	7	8
$1,863.00	$79,508.00	9	10
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
32	7308	0	0
0	0	0	0
$32.00	$7,308.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$263.00	$32,400.00	2	2
$1,632.00	$54,416.00	7	8
$1,895.00	$86,816.00	9	10

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
17692	102732	18	30
20087	110932	14	67
$37,779.00	$213,664.0	32	97
16842	116207	11	27
26848	118571	9	50
$43,690.00	$234,778.0	20	77
12831	91559	7	22
12398	131679	3	19
$25,229.00	$223,238.0	10	41
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$47,365.00	$310,498.0	36	79
$59,333.00	$361,182.0	26	136
$106,698.0	$671,680.0	62	215

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
8385	34673	4	13
25471	79561	18	52
$33,856.00	$114,234.0	22	65
2178	25873	1	3
2797	31714	0	4
$4,975.00	$57,587.00	1	7

1795	19137	0	1
661	14623	0	3
$2,456.00	$33,760.00	0	4
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$12,358.00	$79,683.00	5	17
$28,929.00	$125,898.0	18	59
$41,287.00	$205,581.0	23	76

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure - Outpatient - PMPM	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/1,000 Member Years**
$24.94	$155.79	293.51	643.46
$24.54	$128.69	231.21	768.79
$24.67	$137.87	252.31	726.35
$31.48	$208.99	227.33	519.62
$39.12	$196.21	279.43	962.48
$35.38	$202.46	253.97	746.03
$27.35	$220.16	156.72	514.93
$21.16	$244.09	58.25	427.18
$24.03	$232.97	103.99	467.94
NA	NA	NA	NA
NA	NA	NA	NA
NA	NA	NA	NA
$27.56	$187.36	241.23	574.85
$27.19	$164.33	211.13	751.08
$27.34	$173.61	223.26	680.10

Relative Resource Use for People With Asthma (RAS)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area:						
Eligible Population						
Category	**Eligible Population**					
Total	365					
Exclusions (required)	1					
With Comorbidity	31					
Without Comorbidity	334					
Medical and Pharmacy Ben						
Age	**Medical Benefit Member Months**					
	Member Months (Asthma with Comorbidity)			**Member Months (Asthr Comorbidity**		
	Male	**Female**	**Total**	**Male**	**Female**	
5-17*	11	36	47	1884	1102	
18-44	91	168	259	252	638	
45-50	11	48	59	0	120	
Total	113	252	365	2,136	1,860	
*** Include any Member Months that occur at age 4 in the 5-17 age category.**						
Asthma with Comorbidity						
Age	**Sex**	**Total Standard Cost by Service Category,**				
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	
5-17	**M**	0	0	623	0	
	F	27174	684	3109	0	
	Total	$27,174.00	$684.00	$3,732.00	$0.00	
18-44	**M**	34307	717	5466	2008	
	F	33942	1422	16564	1647	
	Total	$68,249.00	$2,139.00	$22,030.00	$3,655.00	
45-50	**M**	0	0	1400	0	
	F	32516	909	6925	2596	
	Total	$32,516.00	$909.00	$8,325.00	$2,596.00	
Total	**M**	$34,307.00	$717.00	$7,489.00	$2,008.00	
	F	$93,632.00	$3,015.00	$26,598.00	$4,243.00	
	Total	$127,939.0	$3,732.00	$34,087.00	$6,251.00	
Asthma without Comorbidity						
Age	**Sex**	**Total Standard Cost by Service Category,**				
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	
5-17	**M**	37881	1944	72487	323	
	F	22440	1388	45820	4	
	Total	$60,321.00	$3,332.00	$118,307.0	$327.00	
18-44	**M**	3466	642	4850	0	
	F	74963	3908	28476	4260	
	Total	$78,429.00	$4,550.00	$33,326.00	$4,260.00	
45-50	**M**	0	0	0	0	
	F	0	456	4651	0	
	Total	$0.00	$456.00	$4,651.00	$0.00	
	M	$41,347.00	$2,586.00	$77,337.00	$323.00	

Total	**F**	$97,403.00	$5,752.00	$78,947.00	$4,264.00
	Total	$138,750.0	$8,338.00	$156,284.0	$4,587.00

Asthma Totals

Age	**Sex**	**Total standard Cost by Service Category,**			
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**
5-17	**M**	$19.99	$1.03	$38.58	$0.17
	F	$43.60	$1.82	$43.00	$0.00
	Total	$28.85	$1.32	$40.24	$0.11
18-44	**M**	$110.13	$3.96	$30.08	$5.85
	F	$135.12	$6.61	$55.88	$7.33
	Total	$127.66	$5.82	$48.18	$6.89
45-50	**M**	$0.00	$0.00	$127.27	$0.00
	F	$193.55	$8.13	$68.90	$15.45
	Total	$181.65	$7.63	$72.49	$14.50
Total	**M**	$33.64	$1.47	$37.72	$1.04
	F	$90.45	$4.15	$49.97	$4.03
	Total	$61.15	$2.77	$43.65	$2.49

None, Spec Proj: None)

efit Member Months						
	Pharmacy Benefit Member Months					
na without)	Member Months (Asthma with Comorbidity)			Member Months (Asthma without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
2,986	11	36	47	1884	1102	2,986
890	91	168	259	252	638	890
120	11	48	59	0	120	120
3,996	113	252	365	2,136	1,860	3,996

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
4	2078	0	0
402	3929	3	14
$406.00	$6,007.00	3	14
8044	15634	6	13
7145	41758	5	16
$15,189.00	$57,392.00	11	29
93	3781	0	0
5750	17446	3	8
$5,843.00	$21,227.00	3	8
$8,141.00	$21,493.00	6	13
$13,297.00	$63,133.00	11	38
$21,438.00	$84,626.00	17	51

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
12477	149364	6	74
3463	94845	4	28
$15,940.00	$244,209.0	10	102
793	34445	1	7
19657	73005	10	46
$20,450.00	$107,450.0	11	53
0	0	0	0
828	12793	0	2
$828.00	$12,793.00	0	2
$13,270.00	$183,809.0	7	81

$23,948.00	$180,643.0	14	76
$37,218.00	$364,452.0	21	157

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years	ED Visits/1,000 Member Years
$6.59	$79.92	37.99	468.60
$3.40	$86.80	73.81	442.88
$5.39	$82.50	51.43	458.95
$25.76	$146.00	244.90	699.71
$33.25	$142.39	223.33	923.08
$31.02	$143.47	229.77	856.40
$8.45	$343.73	0.00	0.00
$39.15	$179.99	214.29	714.29
$37.27	$190.06	201.12	670.39
$9.52	$91.29	69.36	501.56
$17.63	$115.42	142.05	647.73
$13.45	$102.98	104.56	572.35

Relative Resource Use for People With Acute Lower Back Pain (RLB)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec				
Eligible Population				
Category	**Eligible Population**			
Total	NR			
Exclusions (required)	NR			
Medical and Pharmacy Benefit Member Months				
Age	**Medical Benefit Member Months (Acute Low Back Pain)**			**Pharmacy E (Acut**
	Male	**Female**	**Total**	**Male**
18-44*	NR	NR	NR	NR
45-50	NR	NR	NR	NR
Total	NR	NR	NR	NR
*** Include any Member Months that occur at age 17 in the 18-44 age category.**				

Age	**Sex**	**Total Standard Cost by Servic**		
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**
18-44	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR
45-50	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR
Total	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR

Low Back Pain To				
Age	**Sex**	**Total Standard Cost by Servic**		
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**
18-44	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR
45-50	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR
Total	**M**	NR	NR	NR
	F	NR	NR	NR
	Total	NR	NR	NR

Area: None, Spec Proj: None)

Benefit Member Months e Low Back Pain)	
Female	Total
NR	NR
NR	NR
NR	NR

ce Category, Age, and Gender			Total Service Frequency by Service Category, Age, and Gender		
Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits	MRIs
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR

tals					
ce Category, Age, and Gender			Total Service Frequency by Service Category, Age, and Gender		
Surgery and Procedure - Inpatient - PMPM	Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years	ED Visits/1,000 Member Years	MRIs/1,000 Member Years
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR

Relative Resource Use for People With Cardiovascular Conditions (RCA)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: Nc			
Eligible Population			
Category	**Eligible Population**	**Category**	**Eligible Population**
Total	30		
Exclusions (required)	2		
CHF With Comorbidity	2	**Angina With**	3
CHF Without Comorbidity	0	**Angina Without Comorbidit**	1
AMI With Comorbidity	3	**CAD With Comorbidit**	19
AMI Without Comorbidity	0	**CAD Without**	2

Medical Benefit Meml					
Age	**Member Months (CHF With Comorbidity)**			**Member Months (CHF Comorbidity)**	
	Male	**Female**	**Total**	**Male**	**Female**
18-44	12	0	12	0	0
45-54	12	0	12	0	0
55-64	0	0	0	0	0
65-75	0	0	0	0	0
Total	24	0	24	0	0
Age	**Member Months (Angina With Comorbidity)**			**Member Months (Angi Comorbidity)**	
	Male	**Female**	**Total**	**Male**	**Female**
18-44	0	12	12	0	0
45-54	0	24	24	0	12
55-64	0	0	0	0	0
65-75	0	0	0	0	0
Total	0	36	36	0	12

Pharmacy Benefit Mem					
Age	**Member Months (CHF With Comorbidity)**			**Member Months (CHF Comorbidity)**	
	Male	**Female**	**Total**	**Male**	**Female**
18-44	12	0	12	0	0
45-54	12	0	12	0	0
55-64	0	0	0	0	0
65-75	0	0	0	0	0
Total	24	0	24	0	0
Age	**Member Months (Angina With Comorbidity)**			**Member Months (Angi Comorbidity)**	
	Male	**Female**	**Total**	**Male**	**Female**
18-44	NR	NR	NR	0	0
45-54	NR	NR	NR	0	12
55-64	NR	NR	NR	0	0
65-75	NR	NR	NR	0	0
Total	NR	NR	NR	0	12

CHF with Comorbidity		
Age	**Sex**	**Total Standard Cost by Service Category,**

Age	Sex	Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	75000	2500	2500	1037
	F	0	0	0	0
	Total	$75,000.00	$2,500.00	$2,500.00	$1,037.00
45-54	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$75,000.00	$2,500.00	$2,500.00	$1,037.00
	F	$0.00	$0.00	$0.00	$0.00
	Total	$75,000.00	$2,500.00	$2,500.00	$1,037.00

CHF without Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
45-54	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$0.00	$0.00	$0.00	$0.00
	F	$0.00	$0.00	$0.00	$0.00
	Total	$0.00	$0.00	$0.00	$0.00

AMI with Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
45-54	M	0	0	0	0
	F	40954	1697	2659	1270
	Total	$40,954.00	$1,697.00	$2,659.00	$1,270.00
55-64	M	0	253	696	0
	F	0	0	0	0
	Total	$0.00	$253.00	$696.00	$0.00

65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$0.00	$253.00	$696.00	$0.00
	F	$40,954.00	$1,697.00	$2,659.00	$1,270.00
	Total	$40,954.00	$1,950.00	$3,355.00	$1,270.00
AMI without Comorbidity					
Age	**Sex**	**Total Standard Cost by Service Category,**			
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**
18-44	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
45-54	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$0.00	$0.00	$0.00	$0.00
	F	$0.00	$0.00	$0.00	$0.00
	Total	$0.00	$0.00	$0.00	$0.00
Angina with Comorbidity					
Age	**Sex**	**Total Standard Cost by Service Category,**			
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**
18-44	M	0	0	0	0
	F	63082	1247	1371	8250
	Total	$63,082.00	$1,247.00	$1,371.00	$8,250.00
45-54	M	0	0	0	0
	F	0	456	1607	0
	Total	$0.00	$456.00	$1,607.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$0.00	$0.00	$0.00	$0.00
	F	$63,082.00	$1,703.00	$2,978.00	$8,250.00
	Total	$63,082.00	$1,703.00	$2,978.00	$8,250.00
Angina without Comorbidity					
Age	**Sex**	**Total Standard Cost by Service Category,**			

Age	Sex	Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
45-54	M	0	0	0	0
	F	0	0	169	0
	Total	$0.00	$0.00	$169.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$0.00	$0.00	$0.00	$0.00
	F	$0.00	$0.00	$169.00	$0.00
	Total	$0.00	$0.00	$169.00	$0.00

CAD with Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	0	0	77	0
	F	0	0	0	0
	Total	$0.00	$0.00	$77.00	$0.00
45-54	M	9134	170	4069	2937
	F	14373	726	2965	1326
	Total	$23,507.00	$896.00	$7,034.00	$4,263.00
55-64	M	0	304	3400	0
	F	8300	868	6463	1903
	Total	$8,300.00	$1,172.00	$9,863.00	$1,903.00
65-75	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	M	$9,134.00	$474.00	$7,546.00	$2,937.00
	F	$22,673.00	$1,594.00	$9,428.00	$3,229.00
	Total	$31,807.00	$2,068.00	$16,974.00	$6,166.00

CAD without Comorbidity

Age	Sex	Total Standard Cost by Service Category,			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	Surgery and Procedure -
18-44	M	0	0	0	0
	F	17080	1795	99	80
	Total	$17,080.00	$1,795.00	$99.00	$80.00
45-54	M	0	0	0	0
	F	0	0	1069	0
	Total	$0.00	$0.00	$1,069.00	$0.00
55-64	M	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00

65-75	**M**	0	0	0	0
	F	0	0	0	0
	Total	$0.00	$0.00	$0.00	$0.00
Total	**M**	$0.00	$0.00	$0.00	$0.00
	F	$17,080.00	$1,795.00	$1,168.00	$80.00
	Total	$17,080.00	$1,795.00	$1,168.00	$80.00

Cardiovascular Conditions Totals

Age	**Sex**	**Total Standard Cost by Service Category,**			
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**
18-44	**M**	$3,125.00	$104.17	$107.38	$43.21
	F	$3,340.08	$126.75	$61.25	$347.08
	Total	$3,232.54	$115.46	$84.31	$195.15
45-54	**M**	$217.48	$4.05	$96.88	$69.93
	F	$461.06	$23.99	$70.58	$21.63
	Total	$397.91	$18.82	$77.40	$34.15
55-64	**M**	$0.00	$7.74	$56.89	$0.00
	F	$125.76	$13.15	$97.92	$28.83
	Total	$60.14	$10.33	$76.51	$13.79
65-75	**M**	NA	NA	NA	NA
	F	NA	NA	NA	NA
	Total	NA	NA	NA	NA
Total	**M**	$609.67	$23.38	$77.84	$28.80
	F	$684.71	$32.33	$78.10	$61.09
	Total	$654.95	$28.78	$78.00	$48.28

one, Spec Proj: None)

ber Months						
- Without)	Member Months (AMI With Comorbidity)			Member Months (AMI Without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
0	0	0	0	0	0	0
0	0	24	24	0	0	0
0	12	0	12	0	0	0
0	0	0	0	0	0	0
0	12	24	36	0	0	0
na Without)	Member Months (CAD With Comorbidity)			Member Months (CAD Without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
0	12	0	12	0	12	12
12	30	48	78	0	12	12
0	60	66	126	0	0	0
0	0	0	0	0	0	0
12	102	114	216	0	24	24
nber Months						
- Without)	Member Months (AMI With Comorbidity)			Member Months (AMI Without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
0	0	0	0	0	0	0
0	0	24	24	0	0	0
0	12	0	12	0	0	0
0	0	0	0	0	0	0
0	12	24	36	0	0	0
na Without)	Member Months (CAD With Comorbidity)			Member Months (CAD Without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
0	12	0	12	0	12	12
12	30	48	78	0	12	12
0	60	66	126	0	0	0
0	0	0	0	0	0	0
12	102	114	216	0	24	24

Age, and Gender	Total Service Frequency by Service Category, Age, and

Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
244	8759	7	5
0	0	0	0
$244.00	$8,759.00	7	5
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$244.00	$8,759.00	7	5
$0.00	$0.00	0	0
$244.00	$8,759.00	7	5

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
1135	8419	3	10
$1,135.00	$8,419.00	3	10
516	2294	0	2
0	0	0	0
$516.00	$2,294.00	0	2

0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$516.00	$2,294.00	0	2
$1,135.00	$8,419.00	3	10
$1,651.00	$10,713.00	3	12

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	**Pharmacy**	**Inpatient Facility Discharges**	**ED Visits**
0	0	0	0
1564	1166	3	5
$1,564.00	$1,166.00	3	5
0	0	0	0
84	2551	0	8
$84.00	$2,551.00	0	8
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$1,648.00	$3,717.00	3	13
$1,648.00	$3,717.00	3	13

Age, and Gender	Total Service Frequency by Service Category, Age, and

Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
4	543	0	0
$4.00	$543.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$4.00	$543.00	0	0
$4.00	$543.00	0	0

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
16	3395	0	0
0	0	0	0
$16.00	$3,395.00	0	0
3454	23081	1	8
968	10499	1	11
$4,422.00	$33,580.00	2	19
4915	10936	0	0
1218	25015	1	5
$6,133.00	$35,951.00	1	5
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$8,385.00	$37,412.00	1	8
$2,186.00	$35,514.00	2	16
$10,571.00	$72,926.00	3	24

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
0	0	0	0
4	78	2	2
$4.00	$78.00	2	2
0	0	0	0
28	4097	0	0
$28.00	$4,097.00	0	0
0	0	0	0
0	0	0	0
$0.00	$0.00	0	0

0	0	0	0
0	0	0	0
$0.00	$0.00	0	0
$0.00	$0.00	0	0
$32.00	$4,175.00	2	2
$32.00	$4,175.00	2	2

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure - Outpatient - PMPM	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/1,000 Member Years**
$10.83	$506.42	3,500.00	2,500.00
$65.33	$103.67	2,500.00	3,500.00
$38.08	$372.17	3,000.00	3,000.00
$82.24	$549.55	285.71	2,285.71
$18.49	$271.97	400.00	2,900.00
$35.02	$356.45	370.37	2,740.74
$75.43	$183.75	0.00	333.33
$18.45	$379.02	181.82	909.09
$48.18	$277.14	86.96	608.70
NA	NA	NA	NA
NA	NA	NA	NA
NA	NA	NA	NA
$66.27	$351.20	695.65	1,304.35
$23.83	$300.97	571.43	2,342.86
$40.66	$323.18	620.69	1,931.03

Relative Resource Use for People With Hypertension (RHY)					
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec					
Medical and Pharmacy Benefit Member Months					
Category	Eligible Population				
Total	174				
Exclusions (required)	271				
Medical and Pharmacy Benefit Member Months					
Age	Medical Benefit Member Months			Pharmacy E	
	Male	Female	Total	Male	
18-44	412	372	784	412	
45-54	334	285	619	334	
55-64	275	320	595	275	
65-85	0	0	0	0	
Total	1,021	977	1,998	1,021	
Uncomplicated Hypertensio					
Age	Sex	Total Standard Cost by Servic			
		Inpatient Facility	E & M - Inpatient	E & M - Outpatient	
18-44	M	113636	3776	14745	
	F	50473	1272	15219	
	Total	$164,109.0	$5,048.00	$29,964.00	
45-54	M	99963	4449	18222	
	F	22383	1214	14574	
	Total	$122,346.0	$5,663.00	$32,796.00	
55-64	M	101090	3940	11831	
	F	0	152	14564	
	Total	$101,090.0	$4,092.00	$26,395.00	
65-85	M	0	0	0	
	F	0	0	0	
	Total	$0.00	$0.00	$0.00	
Total	M	$314,689.0	$12,165.00	$44,798.00	
	F	$72,856.00	$2,638.00	$44,357.00	
	Total	$387,545.0	$14,803.00	$89,155.00	
Uncomplicated Hypertension T					
Age	Sex	Total Standard Cost by Servic			
		Inpatient Facility - PMPM	E & M - Inpatient - PMPM	E & M - Outpatient - PMPM	
18-44	M	$275.82	$9.17	$35.79	
	F	$135.68	$3.42	$40.91	
	Total	$209.32	$6.44	$38.22	
45-54	M	$299.29	$13.32	$54.56	
	F	$78.54	$4.26	$51.14	
	Total	$197.65	$9.15	$52.98	
	M	$367.60	$14.33	$43.02	

55-64	**F**	$0.00	$0.48	$45.51
	Total	$169.90	$6.88	$44.36
65-85	**M**	NA	NA	NA
	F	NA	NA	NA
	Total	NA	NA	NA
Total	**M**	$308.22	$11.91	$43.88
	F	$74.57	$2.70	$45.40
	Total	$193.97	$7.41	$44.62

Area: None, Spec Proj: None)

Benefit Member Months	
Female	Total
372	784
285	619
320	595
0	0
977	1,998

on				
ce Category, Age, and Gender			Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
11736	8083	27153	6	34
5533	8041	17141	7	16
$17,269.00	$16,124.00	$44,294.00	13	50
10422	15596	28314	11	18
56	3453	21626	3	5
$10,478.00	$19,049.00	$49,940.00	14	23
5036	7474	24174	17	11
0	9697	35724	0	11
$5,036.00	$17,171.00	$59,898.00	17	22
0	0	0	0	0
0	0	0	0	0
$0.00	$0.00	$0.00	0	0
$27,194.00	$31,153.00	$79,641.00	34	63
$5,589.00	$21,191.00	$74,491.00	10	32
$32,783.00	$52,344.00	$154,132.0	44	95

otals				
ce Category, Age, and Gender			Total Service Frequency by Service Category, Age, and	
Surgery and Procedure - Inpatient - PMPM	Surgery and Procedure - Outpatient - PMPM	Pharmacy - PMPM	Inpatient Facility Discharges / 1,000 Member Years	ED Visits/ 1,000 Member Years
$28.49	$19.62	$65.91	174.76	990.29
$14.87	$21.62	$46.08	225.81	516.13
$22.03	$20.57	$56.50	198.98	765.31
$31.20	$46.69	$84.77	395.21	646.71
$0.20	$12.12	$75.88	126.32	210.53
$16.93	$30.77	$80.68	271.41	445.88
$18.31	$27.18	$87.91	741.82	480.00

$0.00	$30.30	$111.64	0.00	412.50
$8.46	$28.86	$100.67	342.86	443.70
NA	NA	NA	NA	NA
NA	NA	NA	NA	NA
NA	NA	NA	NA	NA
$26.63	$30.51	$78.00	399.61	740.45
$5.72	$21.69	$76.24	122.82	393.04
$16.41	$26.20	$77.14	264.26	570.57

Relative Resource Use for People With COPD (RCO)						
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: I						
Eligible Population						
Category	**Eligible Population**					
Total	NR					
Exclusions (required)	NR					
With Comorbidity	NR					
Without Comorbidity	NR					
Age	**Member Benefit Member Months**					
	Member Months (With Comorbidity)			**Member Months (W Comorbidity**		
	Male	**Female**	**Total**	**Male**	**Female**	
42-44	NR	NR	NR	NR	NR	
45-64	NR	NR	NR	NR	NR	
65-74	NR	NR	NR	NR	NR	
75+	NR	NR	NR	NR	NR	
Total	NR	NR	NR	NR	NR	
COPD with Comorbidity						
Age	**Sex**	**Total Standard Cost by Service Category,**				
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	
42-44	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
45-64	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
65-74	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
75+	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
Total	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
COPD without Comorbidity						
Age	**Sex**	**Total Standard Cost by Service Category,**				
		Inpatient Facility	**E & M - Inpatient**	**E & M - Outpatient**	**Surgery and Procedure -**	
42-44	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
45-64	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	
	Total	NR	NR	NR	NR	
65-74	**M**	NR	NR	NR	NR	
	F	NR	NR	NR	NR	

	Total	NR	NR	NR	NR
75+	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
COPD Totals					
Age	**Sex**	**Total Standard Cost by Service Category,**			
		Inpatient Facility - PMPM	**E & M - Inpatient - PMPM**	**E & M - Outpatient - PMPM**	**Surgery and Procedure - Inpatient - PMPM**
42-44	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
45-64	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
65-74	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
75+	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR
Total	**M**	NR	NR	NR	NR
	F	NR	NR	NR	NR
	Total	NR	NR	NR	NR

None, Spec Proj: None)

	Pharmacy Benefit Member Months					
Without)	Member Months (With Comorbidity)			Member Months (Without Comorbidity)		
Total	Male	Female	Total	Male	Female	Total
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure -	Pharmacy	Inpatient Facility Discharges	ED Visits
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Age, and Gender		Total Service Frequency by Service Category, Age, and	
Surgery and Procedure - Outpatient - PMPM	**Pharmacy - PMPM**	**Inpatient Facility Discharges / 1,000 Member Years**	**ED Visits/ 1,000 Member Years**
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR
NR	NR	NR	NR

Board Certification (BCR)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Type of Physician	Number of Physicians	Board Certification	
		Number	Percent
Family Medicine	NR	NR	NR
Internal Medicine	NR	NR	NR
OB/GYN physicians	NR	NR	NR
Pediatricians	NR	NR	NR
Geriatricians	NR	NR	NR
Other physician specialists	NR	NR	NR

Enrollment by Product Line: Total (ENPA)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	**Male Member Months**	**Female Member Months**	**Total Member Months**
<1	7023	6118	13,141
1-4	26473	24709	51,182
5-9	26120	24743	50,863
10-14	21354	20405	41,759
15-17	11569	11620	23,189
18-19	4821	6385	11,206
0-19 Subtotal	97,360	93,980	191,340
0-19 Subtotal: %	76.20%	61.52%	68.21%
20-24	5287	14360	19,647
25-29	4556	12011	16,567
30-34	3788	9051	12,839
35-39	3340	7195	10,535
40-44	3771	5089	8,860
20-44 Subtotal	20,742	47,706	68,448
20-44 Subtotal: %	16.23%	31.23%	24.40%
45-49	3469	4032	7,501
50-54	2770	3121	5,891
55-59	2224	2446	4,670
60-64	1210	1474	2,684
45-64 Subtotal	9,673	11,073	20,746
45-64 Subtotal: %	7.57%	7.25%	7.40%
65-69	0	0	0
70-74	0	0	0
75-79	0	0	0
80-84	0	0	0
85-89	0	0	0
>=90	0	0	0
>=65 Subtotal	0	0	0
>=65 Subtotal: %	0.00%	0.00%	0.00%
Age Unknown	0	0	0
Total	127,775	152,759	280,534

Enrollment by Product Line: Dual Eligibles (ENPB)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	**Male Member Months**	**Female Member Months**	**Total Member Months**
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by Product Line: Disabled (ENPC)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	Male Member Months	Female Member Months	Total Member Months
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by Product Line: Other (ENPD)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Age	**Male Member Months**	**Female Member Months**	**Total Member Months**
<1	NR	NR	NR
1-4	NR	NR	NR
5-9	NR	NR	NR
10-14	NR	NR	NR
15-17	NR	NR	NR
18-19	NR	NR	NR
0-19 Subtotal	NR	NR	NR
0-19 Subtotal: %	NR	NR	NR
20-24	NR	NR	NR
25-29	NR	NR	NR
30-34	NR	NR	NR
35-39	NR	NR	NR
40-44	NR	NR	NR
20-44 Subtotal	NR	NR	NR
20-44 Subtotal: %	NR	NR	NR
45-49	NR	NR	NR
50-54	NR	NR	NR
55-59	NR	NR	NR
60-64	NR	NR	NR
45-64 Subtotal	NR	NR	NR
45-64 Subtotal: %	NR	NR	NR
65-69	NR	NR	NR
70-74	NR	NR	NR
75-79	NR	NR	NR
80-84	NR	NR	NR
85-89	NR	NR	NR
>=90	NR	NR	NR
>=65 Subtotal	NR	NR	NR
>=65 Subtotal: %	NR	NR	NR
Age Unknown	NR	NR	NR
Total	NR	NR	NR

Enrollment by State (EBS)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
State	Number
Alabama	NR
Alaska	NR
Arizona	NR
Arkansas	NR
California	NR
Colorado	NR
Connecticut	NR
Delaware	NR
District of Columbia	NR
Florida	NR
Georgia	NR
Hawaii	NR
Idaho	NR
Illinois	NR
Indiana	NR
Iowa	NR
Kansas	NR
Kentucky	NR
Louisiana	NR
Maine	NR
Maryland	NR
Massachusetts	NR
Michigan	NR
Minnesota	NR
Mississippi	NR
Missouri	NR
Montana	NR
Nebraska	NR
Nevada	NR
New Hampshire	NR
New Jersey	NR
New Mexico	NR
New York	NR
North Carolina	NR
North Dakota	NR
Ohio	NR
Oklahoma	NR
Oregon	NR
Pennsylvania	NR
Rhode Island	NR
South Carolina	NR
South Dakota	NR
Tennessee	NR
Texas	NR
Utah	NR
Vermont	NR
Virginia	NR
Washington	NR
West Virginia	NR
Wisconsin	NR
Wyoming	NR

American Samoa	NR
Federated States of Micronesia	NR
Guam	NR
Commonwealth of Northern	NR
Puerto Rico	NR
Virgin Islands	NR
Other	NR
TOTAL	NR

Race/Ethnicity Diversity of Membership (RDM)				
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec				
Eligible Population				
Race/Ethnicity Percentage of Data Collected Using Direct Data Collection Methods		Race/Ethnicity Percentage of Data Collected Using Indirect Data Collection		
Direct number of members	28443	Indirect number of members	0	
Total unduplicated membership during the measurement year (this number represents the total number of members regardless of data collection method)	28443	Total unduplicated membership during the measurement year (this number represents the total number of members regardless	28443	
Direct number and percentage of members	100.00%	Indirect (e.g. surname analysis/geo-coding) number and percentage	0.00%	
CMS/State databases percentage of members	0			
Other Percentage of Members	0			

Race	Hispanic or Latino		Not Hispanic or Latino	
	Number	Percentage	Number	Percentage
White	0	0.00%	2320	12.82%
Black or African American	0	0.00%	249	1.38%
American-Indian and Alaska Native	0	0.00%	55	0.30%
Asian	0	0.00%	3017	16.67%
Native Hawaiian and Other Pacific Islanders	0	0.00%	3902	21.56%
Some Other Race	0	0.00%	680	3.76%
Two or More Races	653	100.00%	7879	43.53%
Unknown	0	0.00%	0	0.00%
Declined	00	0.00%	0	0.00%
Total	653	100.00%	18,102	100.00%
Direct/Indirect Percentage of plan members				

Measure	Percentage	Measure	Percentage
Percentage of members for whom the organization has race information through direct data collection methods	0.66	**Percentage of members for whom the organization has race information through indirect data**	0
Percentage of members for whom the organization has ethnicity information through direct data collection methods	0.66	**Percentage of members for whom the organization has ethnicity information through indirect**	0

Area: None, Spec Proj: None)

Unknown Ethnicity		Declined Ethnicity		Total	
Number	Percentage	Number	Percentage	Number	Percentage
0	0.00%	0	0.00%	2,320	8.16%
0	0.00%	0	0.00%	249	0.88%
0	0.00%	0	0.00%	55	0.19%
0	0.00%	0	0.00%	3,017	10.61%
0	0.00%	0	0.00%	3,902	13.72%
0	0.00%	0	0.00%	680	2.39%
0	0.00%	0	0.00%	8,532	30.00%
9450	100.00%	0	0.00%	9,450	33.22%
0	0.00%	238	100.00%	238	0.84%
9,450	100.00%	238	100.00%	28,443	100.00%

Language Diversity of Membership (LDM)			
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)			
Percentage of Members With Known Language Value from Each Data Source			
Category	Health Plan Direct	CMS/State Databases	Other Third-Party Source
Spoken Language Preferred for Health Care*	1	NR	NR
Preferred Language for Written Materials*	1	NR	NR
Other Language Needs*	0	NR	NR
*Enter percentage as a value between 0 and 1.			

Spoken Language Preferred for Health Care		
	Number	Percentage
English	10261	36.08%
Non-English	497	1.75%
Unknown	17685	62.18%
Declined	0	0.00%
Total: this should sum to 100%	28,443	100.00%

Language Preferred for Written Materials		
	Number	Percentage
English	5961	20.96%
Non-English	107	0.38%
Unknown	22375	78.67%
Declined	0	0.00%
Total: this should sum to 100%	28,443	100.00%

Other Languages Needs		
	Number	Percentage
English	0	0.00%
Non-English	0	0.00%
Unknown	28443	100.00%
Declined	0	0.00%
Total: this should sum to 100%	28,443	100.00%

Weeks of Pregnancy at Time of Enrollment in MCO (WOP)		
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)		
Measurement Year		
Measurement Year	NR	
Weeks of Pregnancy	Number	Percentage
< 0 weeks	NR	NR
1-12 weeks	NR	NR
13-27 weeks	NR	NR
28 or more weeks	NR	NR
Unknown	NR	NR
Total	NR	NR

Total Membership (TLM)	
Kaiser Foundation Health Plan, Inc. - Hawaii (Org ID: 124, SubID: 4019, Medicaid, Spec Area: None, Spec Proj: None)	
Product/Product Line	Total Number of Members*
HMO (Total)	216,816
Medicaid	23959
Commercial	168346
Medicare (cost or risk)	24511
Other	0
PPO (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
POS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
FFS (Total)	0
Medicaid	0
Commercial	0
Medicare (cost or risk)	0
Other	0
Total	216,816
* Total number of members in each category as of December 31 of the measurement year.	

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

Kaiser QUEST Medical FY 2010		Age Groups							
		Total	**<1**	**1-2***	**3-5**	**6-9**	**10-14**	**15-18**	**19-20**
1. Total Individuals Eligible for EPSDT	CN	18,410	1,023	2,478	3,332	3,686	3,801	2,822	1,268
	MN	0							
	Total	18,410	1,023	2,478	3,332	3,686	3,801	2,822	1,268
1b. Total Individuals Eligible for EPSDT for 90 Continuous Days	CN	15,329	678	2,098	2,878	3,221	3,370	2,413	671
	MN	0							
	Total	15,329	678	2,098	2,878	3,221	3,370	2,413	671
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN	4,083	25	303	490	976	1,225	945	119
	MN	0							
	Total	4,083	25	303	490	976	1,225	945	119
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			5	2	1	1/2	3/5	1/2	1/2
3a. Total Months of Eligibility	CN	189,943.02	5,644.30	26,217.63	35,996.42	40,017.70	41,412.74	30,224.51	10,429.72
	MN	0.00							
	Total	189,943.02	5,644.30	26,217.63	35,996.42	40,017.70	41,412.74	30,224.51	10,429.72
3b. Average Period of Eligibility	CN	0.86	0.46	0.88	0.90	0.90	0.91	0.89	0.69
	MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.86	0.46	0.88	0.90	0.90	0.91	0.89	0.69
4. Expected Number of Screenings per Eligible	CN		2.30	1.76	0.90	0.45	0.54	0.45	0.34
	MN		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total		2.30	1.76	0.90	0.45	0.54	0.45	0.34
5. Expected Number of Screenings	CN	15,153	2,352	4,370	3,000	1,667	2,071	1,259	435
	MN	0	0	0	0	0	0	0	0
	Total	15,153	2,352	4,370	3,000	1,667	2,071	1,259	435
6. Total Screens Received	CN	14,349	2,052	5,564	2,540	1,471	1,550	1,023	149
	MN	0	0	0	0	0	0	0	0
	Total	14,349	2,052	5,564	2,540	1,471	1,550	1,023	149
7. Screening Ratio	CN	0.95	0.87	1.00	0.85	0.88	0.75	0.81	0.34
	MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.95	0.87	1.00	0.85	0.88	0.75	0.81	0.34

*Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

Form HCFA 416 (06-02)

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

Kaiser QUEST Medical FY 2010		Age Groups							
		Total	**<1**	**1-2***	**3-5**	**6-9**	**10-14**	**15-18**	**19-20**
8. Total Eligibles Who Should Receive at Least One Initial or periodic Screen	CN	11,933	1,023	2,478	3,000	1,667	2,071	1,259	435
	MN	0	0	0	0	0	0	0	0
	Total	11,933	1,023	2,478	3,000	1,667	2,071	1,259	435
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN	9,566	821	2,191	2,434	1,443	1,527	1,004	146
	MN	0	0	0	0	0	0	0	0
	Total	9,566	821	2,191	2,434	1,443	1,527	1,004	146
10. PARTICIPANT RATIO	CN	0.80	0.80	0.88	0.81	0.87	0.74	0.80	0.34
	MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.80	0.80	0.88	0.81	0.87	0.74	0.80	0.34
11. Total Eligibles Referred for Corrective Treatment	CN	845	68	255	190	121	111	84	16
	MN	0	0	0	0	0	0	0	0
	Total	845	68	255	190	121	111	84	16
12a. Total Eligibles Receiving Any Dental Services	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12b. Total Eligibles Receiving Preventive Dental Services	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12c. Total Eligibles Receiving Dental Treatment Services	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12d. Total Eligibles Receiving a Sealant on a Permanent Molar	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12e. Total Eligibles Receiving Dental Diagnostic Services	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12f. Total Eligibles Receiving Oral Health Services By a Non-Dentist	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	CN	0	0	0	0	0	0	0	0
	MN	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0
13. Total Eligibles Enrolled in Managed Care	CN	18,410	1,023	2,478	3,332	3,686	3,801	2,822	1,268
	MN	0	0	0	0	0	0	0	0
	Total	18,410	1,023	2,478	3,332	3,686	3,801	2,822	1,268
14. Total Number of Screening Blood Level Tests	CN	1,741	176	1,356	194	9	3	3	
	MN	0	0	0	0				
	Total	1,741	176	1,356	194				

*Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

Form HCFA 416 (06-02)

KAISER PERMANENTE®

Section 80.315

Provider Network and Services

(30 pages maximum not including attachments)

80.315.1 Provider Network Narrative (included in page maximum)

The applicant shall provide a narrative describing how it maintains its provider network serving Medicaid recipients in order to assure that all services are available to members. As part of this narrative, the applicant shall describe:

A. In detail, how it will maintain its network to meets all required access standards required under this RFP, including, but not limited to, capacity standards (for acute care, primary care, and behavioral health) and geographic access requirements;

Kaiser Foundation Health Plan, Inc. (Health Plan) provides most services through its own hospital and clinics; through physicians of the Hawaii Permanente Medical Group, Inc. (HPMG); and, to a much lesser extent, through providers contracted through the Health Plan's Provider Contracting & Relations Department. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST. Services provided through contracted providers accounts for only 2% of all services provided for Kaiser Permanente members.

The Hawaii Region has established regional standards that are monitored and reported to the Regional Quality Committee to ensure there are sufficient numbers of practitioners and access to services in order to provide timely access to medical and behavioral health care and to maintain quality of care. Monitoring of the established standards is conducted by line of business in comparison to other lines business, national averages and percentiles.

For primary care, HPMG leadership tracks the panel sizes of all PCPs in all clinics on a routine basis. Data is shared openly on a shared site on our intranet. Optimal panel sizes are individually determined for each PCP based on specialty, panel acuity, full time equivalent status and other parameters. The data is reviewed monthly to assure resources shift to areas of need. As appropriate, HPMG leadership may close or limit panel size with adjustment in staff supported by clinic Administration at a local clinic level. This helps to maximize health care team performance.

For behavioral health services, the health plan have providers (including psychiatrists, therapists and chemical dependency counselors) located at various clinics throughout Oahu and Maui. Patients are seen as medically indicated. The Behavioral Health Department consistently reviews the needs of their members to ensure staffing ratios are such that timely and appropriate access is available to our members.

B. How it monitors the provider network to ensure that access and availability standards are being met. As part of this description, please specifically address how the applicant ensures that acceptable appointment wait times are met and steps taken in the past, if any, in the past to address deficiencies in this area;

The Hawaii Region has established regional standards as defined in the Regional Accessibility and Regional Availability policies that are monitored and reported to the Regional Quality Committee to ensure there are sufficient numbers of practitioners and sufficient accessibility to services in order to provide timely access to medical and behavioral health care and to maintain quality of care. Monitoring of the established standards are conducted by line of business in comparison to other lines of business, national averages and percentiles and other Medicaid plans in the community.

Regional standards relating to the availability of practitioners include monitoring of geographic distribution of primary care practitioners (PCPs), specialty care practitioners (SCPs) and high-volume care practitioners including OB/GYN and behavioral health practitioners (BHPs). Availability standards are established to ensure sufficient numbers and types of practitioners within the Hawaii Region delivery system. Geo Access analysis

reports are reported to the Regional Quality Committee. A Medicaid-specific Geo Access report is generated.

- The Hawaii Region also monitors member satisfaction with practitioner availability with CAHPS by product line relating to appointment access for routine and urgent care. The Hawaii Region also monitors the percent of time member sees owns PCP when PCP is in clinic as it relates to regular and routine care monitoring.
- Telephone Service Access - The Hawaii Region utilizes several different methodologies for monitoring telephone access including telephone waits and telephone data retrieved from automated call distributors which are reported daily to clinic staff and managers.
- Behavioral Health Service Access - The Hawaii Region utilizes several different methodologies for monitoring behavioral health services including telephone data retrieved from automated call distributors which are reported daily to clinic staff and the manager and urgent care and initial routine office visits from reports generated from the regional and behavioral health reporting systems.

Examples of 2010 initiatives based on regional monitoring are as follows:

Access improvement initiatives in 2010 include:

- Patient Triage and Appointment Scheduling in Primary Care policy created to ensure consistent standardized policy through all clinics.
- Virtual Consult Trial – 4 specialty departments are participating with “hallway sidebar” initiative where specialists take a few minutes to provide PCP with recommendations during the patient’s visit.

As it relates to monitoring of accessibility and availability specific to Medicaid, the Hawaii Region, quarterly access reports are generated to monitor and ensure that there are sufficient numbers of practitioners in our provider network to provide timely access to needed medical care and to maintain quality of care. Kaiser Permanente will monitor access according to the following acceptable wait time standards, as stated in Section 40.230:

- Emergency medical situations – Immediate care (24 hours a day, 7 days a week) and without prior authorization

- Urgent care and PCP pediatric sick visits – Appointments within 24 hours
- PCP adult sick visits – Appointments within 72 hours
- PCP visits (routine visits for adults and children) – Appointments within 21 days
- Visits with a specialist or non-emergency hospital stay – Appointments within 4 weeks or of sufficient timeliness to meet medical necessity.

Using actual appointment data, the reports will indicate the total number of appointment requests, total number of requests that meet the wait time standard, the total number of requests that exceed the wait time standard and the average wait time for those requests that exceed the wait time standard. If any deficiencies are identified, the information will be shared with the appropriate committees with oversight for the leadership teams of the HPMG and clinic operations. The teams will assess the data and develop corrective actions to address the deficiency. Due to Kaiser Permanente's vast provider network it's able to make necessary changes to meet access standards.

Standards specific to Medicaid have been met with no deficiencies identified since monitoring processes were established.

C. How it will provide services when there are either no contracted providers or the number of providers fails to meet the minimum requirement;

Kaiser Permanente has an extensive provider panel, predominantly the Hawaii Permanente Medical Group, Inc. (HPMG), augmented by contracted providers. When services or specialties are not available on a neighbor island, care may be provided on Oahu through our specialty provider panel, or HPMG may increase specialty availability on the neighbor island. In the rare circumstance where we would need the services of a non-Kaiser Permanente non-contracted provider or facility, every attempt will be made to credential and contract with that outside provider. Compensation will be made to providers for emergency care.

D. How it will recruit, retain, and incentivize providers in rural and other historically under-served areas to ensure access to care and services in these areas;

Kaiser Permanente provides care with facilities and providers located geographically across the islands including rural and underserved locations. As a statewide group model HMO, we are able to recruit and retain providers, shift resources as needed, and provide our practitioners with advantages of belonging to a large organization of physicians even when their primary clinic is rural. For example, many of the medical subspecialties based on Oahu rotate out to neighbor island clinics and to other Oahu clinics, as needed.

E. Provide a summary of its PCP policies and procedures that includes information on choosing and selecting a PCP (including the PCP assignment process), describes who may serve as a PCP, referral to specialists, and describes who may serve as a PCP to members with chronic conditions;

HPMG physicians in the departments of Family Practice, Pediatrics, and Internal Medicine serve as Primary Care Physicians (PCPs). Kaiser Permanente finds that linking members to PCPs results in the best quality of care, service, health outcomes, member satisfaction and member retention. The Health Plan encourages each member to choose a PCP and is proactive in providing opportunities for the member to be linked to a PCP of his or her choice. Members may change their PCP or clinic at any time.

QUEST members who have not chosen a PCP are assigned to a clinic to serve as their PCP and establish a “provider home”, based on residence. Members may however use primary care services of any Kaiser Permanente clinic. They may, but need not, choose their physician before seeking clinic care. At each encounter with a primary care provider, a member not linked to a specific PCP is given the choice to:

- Be linked to the physician seen today;
- Select an alternative PCP whom they have already seen;
- Select a PCP at a later medical encounter;
- Decline to be linked to a specific PCP, but select a clinic; or
- Decline to choose either a specific PCP or clinic. Members who decline to choose either a PCP or clinic are assigned to (or remain assigned to) a clinic based on residence.

Prenatal practitioners encourage pregnant women to choose a PCP for the baby during the prenatal period. If no PCP has been chosen by the time of delivery, assignment is made to a PCP serving the baby's siblings or to a PCP at the clinic location nearest the baby's residence, unless otherwise directed by the parent.

PCPs serve members with and without chronic health problems. Primary care includes care for common health problems and for chronic conditions which can be managed on an outpatient basis. PCPs are responsible for the overall management and coordination of health care for members linked to them, including but not limited to:

- Acute care management,
- Chronic disease care management
- Management of special requests
- Continuity of care,
- Referrals and communication with other practitioners
- Coordination of care

Arrangements are made for transition of care for adolescents changing to an adult PCP and for members whose PCP retires or moves or otherwise leaves the present practice.

F. The provider network analysis for its Medicaid business in Hawaii. This analysis shall include:

1. The percent of PCPs who are Board certified; and

90.7%

2. The percent of specialists who are Board certified in the specialty of their predominant practice.

90.8%

80.315.2 Attachment: Required Providers (not included in page maximum)

The applicant shall provide a separate listing of its providers for each island for which it is bidding. Use the format listed below for these listings. Applicants shall include in this listing only providers who have signed a contract. DHS may request from the applicant a sampling of provider contract signature pages for contract verification.

Examples of completed rows are provided as examples.

Provider Type	Island/County (for Oahu include the city)	Provider Name (Last name, First name, Middle Initial)	Accepting new QUEST members (Y/N)?	Any limit on QUEST members (Y/N)?
PCP – Family practitioners, General Practitioners and General Internists	Honolulu, Oahu	Last Name, First Name, MI		
PCP – OB/GYN	Kapolei, Oahu	Last Name, First Name, MI		
Specialist – Cardiologist	Maui County	Last Name, First Name, MI		
Hospital	Kauai	Hospital Name		
Home Health Agency	Hawaii-East	Agency Name		

The applicant shall separate the providers by provider type and listed alphabetically

within the different provider type by last name as follows:

A. PCP providers (PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYN, and clinics. Nurse midwives, pediatric nurse practitioners, and family nurse practitioners shall be listed separately);

B. Certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners;

C. Specialists;

D. Hospitals (the DHS shall assume the hospital is on contract for acute services, outpatient and emergency room unless otherwise noted in the specialty column);

E. Urgent care providers;

F. Emergency transport (including ground and air ambulance) providers;

G. Pharmacies;

H. Laboratories;

I. Radiology providers;

J. Physical, occupational, audiology and speech and language therapy providers;

K. Behavioral health providers (as described in Section 40.220);

L. Home health agencies and hospices;

M. Durable medical equipment and medical suppliers;

N. Non-Emergency transportation providers; and

O. Interpretation/translation service providers.

The applicant shall list each provider once. For example, if an OB/GYN is serving both as a PCP and as a specialist, he or she shall be listed as either a PCP or a specialist, not both.

For provider types that may include a variety of providers the provider listing shall be ordered by specialty. As an example, for the PCP matrix, sort providers by pediatricians, physician assistants, family practitioners, general practitioners, internists, and OB/GYNs.

List nurse midwives, pediatric nurse practitioners, family nurse practitioners and

behavioral health practitioners who are in independent practice separately. If the nurse midwife, pediatric nurse practitioner or family nurse practitioner practice in a physician's office or clinic, he/she shall be listed under the clinic or physician's office as described below.

For clinics serving in the capacity of a PCP, list the clinic and under the clinic name, identify each specific provider (e.g., physician, nurse practitioner, etc.). Clinics may be listed on different provider type network matrices, but the individual provider of the service is listed only once. As an example, the clinic may be listed as a PCP with the clinic's pediatrician. Other physicians serving as specialists shall be listed on the specialty care matrix with the clinic's name. If the clinic also provides interpretation, it shall be listed on the interpretation services matrix.

The specialists list shall include all physicians (e.g. cardiologists, neurologists, ophthalmologists, pulmonologists, etc.) and non-physician services (e.g. optometrists, opticians, podiatrists, etc.), that provide medical services, but are not in the behavioral health service providers.

All behavioral health providers shall be listed on the behavioral health service provider lists and not the specialists list. This includes psychiatrists, psychologists, licensed social workers, case management agencies, residential treatment providers, etc.

In addition to a hard copy of the provider listings, the applicant shall include with its proposal an electronic file of providers in Excel 2010 or lower.

See attached document: 2011 QUEST Network

80.315.3 <u>Attachment: Maps of Providers</u> (not included in page maximum)

The applicant shall include in its proposal maps of the State by island indicating the locations of the following contracted health care providers: PCPs, acute care hospitals, pharmacies, specialists, and behavioral health providers. The applicant shall submit a separate map of their providers Statewide for each of the health care provider groups listed above.

See attached Maps of Providers

80.315.4 Availability of Providers Narrative (included in page maximum)

The applicant shall describe how it will ensure that PCPs fulfill their responsibilities for supervising and coordinating care for all assigned members and include assurances that no PCP has too many members to fulfill their responsibilities. As part of this, the applicant shall describe how it will monitor the performance of specialists or other health care providers who are permitted to serve as a PCP to members with chronic conditions.

PCPs are primary care physicians (MD, DO in Pediatrics, Family Medicine, or Internal Medicine), employed or contracted by the HPMG, therefore part of the integrated Kaiser Permanente medical care program. Their responsibility to their patients and members is also a responsibility to their employer/contractor and to the Health Plan.

HPMG Leadership tracks the panel sizes of all PCPs in all clinics on a routine basis and the data is shared openly on a shared site in our Intranet. Optimal panel sizes are individually determined for each PCP, based on specialty, panel acuity, full time equivalent status and other parameters. The data is reviewed monthly to assure resources shift to areas of need. As appropriate, HPMG may close or limit panel size with adjustments in staff supported by Clinic Administration at a local clinic level. This helps maximize health care team performance. We also track QA flags, admission rates, readmission rates, emergency department (ED) utilization, phone calls abandoned, time to answer phone calls, service complaints and other metrics linked to utilization, access, service and quality.

Kaiser Permanente has structured its primary care delivery in accordance to the principles in the Patient Centered Medical Home and presently has Level III NCQA certification in such for all 16 of our primary care clinics in the State. We have an integrated electronic health record (EHR) system that connects our ambulatory clinics with our Hospital, ED, Lab, Pharmacy and Diagnostic Imaging systems. Each PCP and each primary care treatment team (MD, RN, MA, NP, PharmD, MSW) is responsible for the care of all of its empanelled members. Our EHR is based on "EpicCare" and includes a proprietary population care registry, a "Panel Support Tool" that graphically displays updated chronic disease process and outcome metrics, enabled by our IT integration, for each member in the panel. The metrics are selected on the basis of strength

of clinical evidence and expert consensus that link to evidence-based outcomes. These metrics include, but are not limited to, last BUN, creat, Na, K, Hba1c, FBS, urine microalbumin ratio or urine prot/creat ratio, Cholesterol, HDL, LDL, uric acid, TSH, pain contract, urine drug testing, smoking status, PHQ9, last ED visit, last inpatient discharge, mammmography, PAP, iFOBT, last colonscopy, last flex sig, flu vaccine, tDAP, Pneumovax, 10 yr Framingham CV risk, current meds, meds patient should be on given documented risk data (e.g. ASA, statin, ACE Inhibitor, beta-blocker, etc), last vitals including BMI, diabetic foot screen, diabetic eye screen, beta-agonist vs inhaled corticosteroid Rx use, Pediatric PEx due, ADHD med use, Pediatric immuniations due, etc. Our ambulatory EHR also has links to a FRAX calculator, Drug Interaction library, and E-formulary and References..

80.315.5 <u>Provider Services Narrative – General Requirements</u> (included in page maximum)

The applicant shall provide a comprehensive explanation of how it intends to meet provider services requirements described below to include:

A. A description of how the applicant will meet the timeframes associated with prior authorizations as described in Section 50.900;

Health Plan provides most services through its own hospital and clinics; through physicians of HPMG; and to a much lesser extent, through providers contracted through Health Plan's Provider Contracting & Relations Department. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST. Services provided through contracted providers accounts for only 2% of all services provided for Kaiser Permanente members.

When services or items from an outside provider are needed, an authorization request is submitted and processed through Kaiser Permanente's Authorization and Referral Management Department (ARM). Staff consults with the referring physician to ensure all prior authorization criteria are met. If the requested services meet benefit guidelines, the QUEST Member will be sent to the appropriate non-Kaiser Permanente medical provider. A relatively small volume of prior authorizations allows for manual tracking of performance

from medical review, through the authorization decision, and ending with the notification to the member and provider. Each step of the prior authorization process is monitored to ensure compliance within the allowable timeframes as described in Section 50.900 of the RFP. In the rare occasion that timeframes aren't met, counseling and education are provided.

B. Description of how it will communicate fraud and abuse requirements to providers;

Kaiser Permanente providers and staff are required to complete an annual Compliance Training Program. An integral part of this program is a module dedicated to fraud and abuse. This ongoing teaching process explains how to identify potential risk situations and outlines various ways of reporting fraud and abuse through appropriate channels. It also provides available resources for providers and staff to access. Any mandated changes or new requirements are built into the modules as needed. Non-retaliation for reporting is stressed. Fraud and abuse requirements are also included in provider contracts and may be included in provider newsletters. Kaiser Permanente Hawaii has a regional compliance officer and a compliance department dedicated to the ongoing process of maintaining the highest levels of corporate integrity.

C. A description of how it will process claims in a timely manner, as described in Section 60.310, as well as work with providers to assure that claims are processed timely; and

Health Plan provides most services through its own hospital and clinics; through physicians of HPMG; and to a much lesser extent, through providers contracted through Health Plan's Provider Contracting & Relations Department. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST. Services provided through contracted providers accounts for only 2% of all services provided for Kaiser Permanente members.

The relatively small volume of claims Kaiser Permanente receives will be processed through our claim system. The claims system will have interfaces with our membership and benefits systems as well as input from the provider contracting and Authorization and Referrals

Management areas. The system will have the ability to accept electronic or paper submissions of claims. Electronically submitted claims will go through code editing to ensure submission of valid codes prior to entering the system for adjudication. For paper claims they are scanned in and then go through a similar code scrubbing to ensure valid codes are being submitted by the providers. Once the claims have been "scrubbed", it must pass a series of authorization rules which have built into the system to identify under which circumstances claims require prior authorization or medical review.

In addition to the authorization rules, benefits and provider contracts have been configured into the system. The benefit configurations are how the claim being processed is linked to the actual benefits which the member had at the time of service. The provider configuration allows for the proper adjudication of the contract terms which have been agreed to with the specific provider. Having the authorization rules and benefit and provider configuration within the system allows for the auto adjudication of claims. This means that when a claim comes in there is an automated look-up for the member's medical record number to ensure that the member had eligibility at the time of service. The member's benefits are then pulled in and the contract terms for the provider are accessed. The system can then combines all of the data to automatically calculate the payment so the provider can be paid within the timeframe standards described in Section 60.310.

In addition to the auto adjudication mentioned earlier, the system has reporting capabilities that allow us to monitor not only claims that have been paid, but claims that have been received but not yet adjudicated. This will enhance our ability to monitor claims turnaround time, data entry errors, financial accuracy and overall processing accuracy. Trends identified by claims processors are shared with our Provider Contracting Department for follow-up education.

D. A description of how it will assure that providers meet medically necessary requirements including, but not limited to, EPSDT and screening measures.

The QUEST EPSDT Coordinator works to ensure compliance with EPSDT requirements by providing ongoing education, audit results, training, and support to our providers. Additionally, our Performance Assessment Department measures and monitors mandated

health parameters and guidelines including HEDIS data. Encounter data is obtained from Kaiser Permanente's electronic health record, Kaiser Permanente HealthConnect (KPHC).

KPHC is used to provide feedback to providers. From its home page, there are shortcuts to tools called "How Are We Doing?" and the "Panel Support Tool", which allows providers real-time access to performance measures including preventative care, screening and outcome measures including HEDIS information.

Providers are also prompted when health maintenance issues such as mammography and colorectal screening are due. KPHC also has tools such as well child "smart sets" which have EPSDT-driven, age appropriate prompts built in for history, examination, immunizations, labs and developmental testing.

To support population-based primary and secondary preventive care, we also developed a chronic disease (diabetes, asthma, etc.) patient-based database called the Panel Support Tool. This tool allows primary care physicians to see how their members with chronic diseases are doing in meeting specific quality goals. We also have Panel Support Teams (a multidisciplinary group composed of APRNs, dieticians, and clinical pharmacists) that assist providers in managing certain chronic conditions like hypertension and hyperlipidemia. Social Workers and behavioral health clinicians are also available when needed.

Kaiser Permanente also has specific interventions aimed at disease processes or at-risk groups. For example, we have physician champions for special projects including smoking cessation and childhood obesity that conduct ongoing education programs and support to our providers. .

Our integrated systems allow us to actively measure, monitor and support the delivery of appropriate care to all of our patients.

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
PCP	Family Practice	Maui	Abbott, Sharita	Y	N
PCP	Internist	Maui	Alaimalo, Jed	Y	N
PCP	Family Practice	Kahuku, Oahu	Alik, Wilfred	Y	N
PCP	Family Practice	Kaneohe, Oahu	Among, Janine	N	N
PCP	Pediatrics	Waianae, Oahu	Ancog, Cristeta	Y	N
PCP	Internist	Kaneohe, Oahu	Ansdell, Vernon	Y	N
PCP	Family Practice	Maui	Au, Melinda	Y	N
PCP	Family Practice	Honolulu, Oahu	Au, Vincent	Y	N
PCP	Internist	Kailua, Oahu	Bender, Catherine	Y	N
PCP	Pediatrics	Honolulu, Oahu	Besenbruch, Valerie	Y	N
PCP	Family Practice	Maui	Bloedon, William	Y	N
PCP	Family Practice	Maui	Buntuyan, Errol	Y	N
PCP	Internist	Honolulu, Oahu	Cadelina, Arlene	Y	N
PCP	Internist	Honolulu, Oahu	Camara, Lisa	Y	N
PCP	Internist	Honolulu, Oahu	Choy, Aaron	Y	N
PCP	Family Practice	Kailua, Oahu	Chun, Allan	Y	N
PCP	Family Practice	Waianae, Oahu	Chun, Benjamin	N	N
PCP	Family Practice	Waipahu, Oahu	Clevenger, William	N	N
PCP	Family Practice	Waianae, Oahu	Cook-Palmer, Alean	Y	N
PCP	Family Practice	Waipahu, Oahu	Crow, Emilani	Y	N
PCP	Family Practice	Honolulu, Oahu	De Leon, Claire	Y	N
PCP	Internist	Waianae, Oahu	Dizon, Theresa	Y	N
PCP	Internist	Honolulu, Oahu	Doi, Elaine	Y	N
PCP	Pediatrics	Honolulu, Oahu	Dougan, Kenneth	Y	N
PCP	Pediatrics	Maui	Edwards, M	N	N
PCP	Family Practice	Kaneohe, Oahu	Fong, Carol	Y	N
PCP	Internist	Honolulu, Oahu	Fujimoto, Nathan	Y	N
PCP	Family Practice	Maui	Gilbert, Darcel	Y	N
PCP	Internist	Waipahu, Oahu	Gima, Orin	Y	N
PCP	Family Practice	Kaneohe, Oahu	Gosland, Melissa	Y	N
PCP	Internist	Honolulu, Oahu	Greulick, Mary	Y	N
PCP	Pediatrics	Honolulu, Oahu	Hamilton, R	Y	N

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
PCP	Pediatrics	Waipahu, Oahu	Hasegawa, Robyn	Y	N
PCP	Internist	Honolulu, Oahu	Hirose-Ridao, Deborah	Y	N
PCP	Internist	Honolulu, Oahu	Hong, Steven	Y	N
PCP	Internist	Honolulu, Oahu	Howick, Gregory	Y	N
PCP	Internist	Honolulu, Oahu	Inagaki, Wayne	Y	N
PCP	Family Practice	Waianae, Oahu	Inao, Jan	Y	N
PCP	Internist	Honolulu, Oahu	Ing, Hyewon	Y	N
PCP	Pediatrics	Maui	Irwin, Mitchell	Y	N
PCP	Family Practice	Waipahu, Oahu	Jackson, Lenley	Y	N
PCP	Clinic	Honolulu, Oahu	Kaiser Permanente Hawaii – Hawaii Kai Clinic	Y	N
PCP	Clinic	Honolulu, Oahu	Kaiser Permanente Hawaii - Honolulu Clinic	Y	N
PCP	Clinic	Kahuku, Oahu	Kaiser Permanente Hawaii - Kahuku Clinic	Y	N
PCP	Clinic	Kailua, Oahu	Kaiser Permanente Hawaii - Kailua Clinic	Y	N
PCP	Clinic	Kapolei, Oahu	Kaiser Permanente Hawaii - Kapolei Clinic	Y	N
PCP	Clinic	Maui	Kaiser Permanente Hawaii - Kihei Clinic	Y	N
PCP	Clinic	Kaneohe, Oahu	Kaiser Permanente Hawaii - Koolau Clinic	Y	N
PCP	Clinic	Maui	Kaiser Permanente Hawaii - Lahaina Clinic	Y	N
PCP	Clinic	Honolulu, Oahu	Kaiser Permanente Hawaii - Mapunapuna Clinic	Y	N
PCP	Clinic	Maui	Kaiser Permanente Hawaii – Maui Lani Clinic	Y	N
PCP	Clinic	Waianae, Oahu	Kaiser Permanente Hawaii - Nanaikeola Clinic	Y	N
PCP	Clinic	Maui	Kaiser Permanente Hawaii – Wailuku Clinic	Y	N

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PCP	Clinic	Waipahu, Oahu	Kaiser Permanente Hawaii – Waipio Clinic	Y	N
PCP	Internist	Honolulu, Oahu	Kaneshiro-Yeung, Brandy	Y	N
PCP	Family Practice	Maui	Kato, Bichha	Y	N
PCP	Internist	Honolulu, Oahu	Kim, Timothy	N	N
PCP	Family Practice	Honolulu, Oahu	Kovach, Drew	N	N
PCP	Internist	Honolulu, Oahu	Kuribayashi, Linda	N	N
PCP	Internist	Waianae, Oahu	Kuwaye, Todd	Y	N
PCP	Internist	Waipahu, Oahu	Laderta, Paul	Y	N
PCP	Family Practice	Kailua, Oahu	Latare, Peggy	N	N
PCP	Internist	Honolulu, Oahu	Leong, April	Y	N
PCP	Internist	Honolulu, Oahu	Ling, Cecily	Y	N
PCP	Pediatrics	Maui	Livaudais, Felicitas	N	N
PCP	Clinic	Honolulu, Oahu	Longs Drugs - Pali	Y	N
PCP	Family Practice	Kailua, Oahu	Lum, Landis	Y	N
PCP	Internist	Honolulu, Oahu	Lum, Mark	Y	N
PCP	Internist	Maui	Maguire, Maureen	N	N
PCP	Family Practice	Honolulu, Oahu	Manzoku-Kanja, Kathy	N	N
PCP	Pediatrics	Honolulu, Oahu	Marumoto, Marsha	N	N
PCP	Pediatrics	Waipahu, Oahu	Matsumoto, Brent	Y	N
PCP	Pediatrics	Honolulu, Oahu	Matsuura, Pamela	Y	N
PCP	Family Practice	Honolulu, Oahu	Matyas, Robert	Y	N
PCP	Family Practice	Maui	Meyer, Bernard	Y	N
PCP	Pediatrics	Honolulu, Oahu	Meyers, Philip	Y	N
PCP	Clinic	Kapolei, Oahu	Mina Pharmacy - Kapolei	Y	N
PCP	Internist	Honolulu, Oahu	Minami, Kenneth	Y	N
PCP	Family Practice	Honolulu, Oahu	Monzon, Pamela	Y	N
PCP	Internist	Waipahu, Oahu	Morita, Naomi	N	N
PCP	Internist	Honolulu, Oahu	Motooka, Mitchell	N	N
PCP	Family Practice	Waipahu, Oahu	Nuanez, Paz	N	N
PCP	Internist	Honolulu, Oahu	O'Connor, Brian	Y	N
PCP	Internist	Honolulu, Oahu	Okawa, Grant	N	N

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PCP	Family Practice	Maui	Ouchi, Kimmie	Y	N
PCP	Family Practice	Waipahu, Oahu	Pang, Jennifer	N	N
PCP	Internist	Kaneohe, Oahu	Park, Julia	Y	N
PCP	Family Practice	Waianae, Oahu	Patel, Samir	Y	N
PCP	Family Practice	Waipahu, Oahu	Pescador-Chun, Marie	Y	N
PCP	Internist	Honolulu, Oahu	Quinn, Elizabeth	Y	N
PCP	Family Practice	Maui	Rutherford, Shelley	Y	N
PCP	Family Practice	Maui	Saarheim-Riggs, Anne	Y	N
PCP	Family Practice	Honolulu, Oahu	Sakamoto, Charles	Y	N
PCP	Internist	Maui	Sands, Fredrick	N	N
PCP	Family Practice	Waipahu, Oahu	Shehata, Cherie	Y	N
PCP	Family Practice	Waipahu, Oahu	Shon, Kathryn	N	N
PCP	Family Practice	Waipahu, Oahu	Shultz, Sharyl	Y	N
PCP	Internist	Waipahu, Oahu	Shun, Jonathan	Y	N
PCP	Internist	Honolulu, Oahu	Sierra, Julie	N	N
PCP	Pediatrics	Kaneohe, Oahu	Smith, Linda	Y	N
PCP	Family Practice	Maui	Sugino, Guy	N	N
PCP	Family Practice	Waipahu, Oahu	Takai, Masaki	Y	N
PCP	Family Practice	Kahuku, Oahu	Takashima, William	Y	N
PCP	Internist	Honolulu, Oahu	Takazawa, Lydia	N	N
PCP	Internist	Maui	Talbot, George	N	N
PCP	Internist	Honolulu, Oahu	Tamura, Benjamin	N	N
PCP	Internist	Honolulu, Oahu	Tanabe, Bryan	Y	N
PCP	Internist	Maui	Termulo, Maria	Y	N
PCP	Pediatrics	Honolulu, Oahu	Tim Sing, Patrice	Y	N
PCP	Family Practice	Honolulu, Oahu	Timtim, John	Y	N
PCP	Pediatrics	Honolulu, Oahu	Tom, Jeffrey	N	N
PCP	Internist	Honolulu, Oahu	Tran, Anh	Y	N
PCP	Internist	Honolulu, Oahu	Tsuzaki, Wray	Y	N
PCP	Pediatrics	Honolulu, Oahu	Ueoka, Doreen	Y	N
PCP	Pediatrics	Maui	Ulin, David	Y	N
PCP	Internist	Honolulu, Oahu	Wang, Anthea	Y	N

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PCP	Pediatrics	Kaneohe, Oahu	Waring, Erin	Y	N
PCP	Pediatrics	Kailua, Oahu	Weeks, Bertram	Y	N
PCP	Internist	Honolulu, Oahu	White, Karen	Y	N
PCP	Family Practice	Maui	Wiger, Galen	Y	N
PCP	Internist	Maui	Wilkins, Gary	Y	N
PCP	Pediatrics	Maui	Wilkinson, Norka	Y	N
PCP	Pediatrics	Honolulu, Oahu	Wong, Cindy	N	N
PCP	Family Practice	Waipahu, Oahu	Wong, Lucy	N	N
PCP	Internist	Honolulu, Oahu	Yamashita, James	Y	N
PCP	Family Practice	Kailua, Oahu	Yap, Gary	N	N
PCP	Family Practice	Honolulu, Oahu	Yates, Johnnie	Y	N
PCP	Pediatrics	Waipahu, Oahu	Yee, James	Y	N
PCP	Pediatrics	Waipahu, Oahu	Yim, Dwight	N	N
PCP	Pediatrics	Maui	Yoshikawa, Lisa	Y	N
PCP	Family Practice	Honolulu, Oahu	Young, Christopher	N	N
PCP	Family Practice	Waipahu, Oahu	Young-Ajose, Denise	Y	N
PCP	Internist	Maui	Zaar, Gregory	Y	N
Certified Nurse Midwives	OB/GYN	Kailua, Oahu	Chong Tim, Linda		
Certified Nurse Midwives	OB/GYN	Waipahu, Oahu	Conover, Constance		
Certified Nurse Midwives	OB/GYN	Waipahu, Oahu	Jackson, Brenda		
Certified Nurse Midwives	OB/GYN	Honolulu, Oahu	Turner-Bell, Reagan		
Certified Nurse Midwives	OB/GYN	Waipahu, Oahu	Urbanc, Cindy		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Almeida, Pamela G.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Amell, Charlene M.		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Amina, Susan M.		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	An, Chong Son		
Nurse Practitioner	Family Practice	Hawaii	Aruga, Cheryl K.K.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Camacho, Janet M.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Copp, Cynthia R.		
Nurse Practitioner	Internal Medicine	Maui	DeLima, Annette M.K.		

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Nurse Practitioner	Family Practice	Kaneohe, Oahu	Dettweiler, Elizabeth		
Nurse Practitioner	OB/GYN	Waipio, Oahu	Evanson, Shauna E.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Farley, Kathryn M.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Fujimoto, Ronny S.		
Nurse Practitioner	OB/GYN	Kaneohe, Oahu	Gallagher Felix, Jane G.		
Nurse Practitioner	OB/GYN	Waipio, Oahu	Gawrys, Eileen M.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Gray, Rebecca S.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Gue, Cecilia M.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Gutierrez, Mary L.Y.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Harrison, Lori K.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Hieb, Diane L.		
Nurse Practitioner	Family Practice	Hawaii	Ikeda, Lynn T.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Ing, Dana K.		
Nurse Practitioner	Family Practice	Hawaii	Johnson, Shawna A.H.		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Johnstone, Shelley A.		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Kauwe, Leanne L.Y.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Kawasaki, Mary A.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	King, Christine M.		
Nurse Practitioner	Family Practice	Waipio, Oahu	Kusatsu, Alyson M.		
Nurse Practitioner	Family Practice	Waipio, Oahu	Lagapa, Dionicia A.C.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Lesperance, Michelle A.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Locquiao, Madelyn G.		
Nurse Practitioner	Family Practice	Maui	Luckie, Loriel J.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Madonia, Joyce A.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Marineau, Michelle L.		
Nurse Practitioner	OB/GYN	Waipio, Oahu	Maurer, Lynn E. I.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Mizuo, Mari M.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Myhre, Susan H.		
Nurse Practitioner	Internal Medicine	Maui	Naranjo, Xavier J.		
Nurse Practitioner	Internal Medicine	Maui	Nelson, Amy C.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Nochi, Romy T.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Oshiro, Kiyomi		

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Nurse Practitioner	Pediatrics	Honolulu, Oahu	Pieron, Petri P.M.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Shin, Hyunsun		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Shumock, Laura M.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Stark, Mariailiana J.		
Nurse Practitioner	OB/GYN	Honolulu, Oahu	Stone Murai, Amy		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Sze Schaefer, Winnie		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Takashima, Kellie M.O.		
Nurse Practitioner	Family Practice	Waipio, Oahu	Timm, Toni K.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Tung, Ki M.		
Nurse Practitioner	Internal Medicine	Maui	Vega, Victorio L.		
Nurse Practitioner	Pediatrics	Honolulu, Oahu	Weissbach, Laura M.		
Nurse Practitioner	Family Practice	Maui	Womack, Shelley A.		
Nurse Practitioner	Family Practice	Honolulu, Oahu	Young, Susan L.		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Zhou, Xiaojin		
Nurse Practitioner	Internal Medicine	Honolulu, Oahu	Zhu, Min		
Specialist	Urology	Honolulu, Oahu	Aaberg, Randal		
Specialist	General Surgery	Maui	Abadir, Janet		
Specialist	Reproductive Endocrinology & Infertility	Kailua, Oahu	ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY OF HAWAII, INC.		
Specialist	Substance Abuse	Maui	ALOHA HOUSE, INC.		
Specialist	Pain Mgmt	Honolulu, Oahu	Antoine, Veronica		
Specialist	General Surgery	Honolulu, Oahu	Anzai, Kerri		
Specialist	Urology	Honolulu, Oahu	Aspera, Ann		
Specialist	Optometry	Waipahu, Oahu	Au, Russell		
Specialist	OB/GYN	Maui	Ausbeck, Elizabeth		
Specialist	OB/GYN	Waipahu, Oahu	Bachman, Jolene		
Specialist	Ophthalmology	Honolulu, Oahu	Baum, Kenneth		
Specialist	Orthopedic	Honolulu, Oahu	Beattie, Robert		
Specialist	Hospitalist	Honolulu, Oahu	Bell, David		
Specialist	Dermatology	Honolulu, Oahu	Bessing, Todd G		

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Specialist	OB/GYN	Maui	Bicker, Rebecca		
Specialist	Anesthesia	Honolulu, Oahu	Blaisdell, Lance		
Specialist	Neonatology	Honolulu, Oahu	Boloker, Judd		
Specialist	Adult Endocrinology	Honolulu, Oahu	BORNEMANN, MICHAEL		
Specialist	Nephrology	Honolulu, Oahu	Botev, Rossini		
Specialist	Rheumatology	Honolulu, Oahu	Boulware, Dennis		
Specialist	Peds-Anesthesiology	Honolulu, Oahu	Britten, Alan		
Specialist	Hospitalist	Honolulu, Oahu	Brown, Sarah		
Specialist	OB/GYN	Waipahu, Oahu	Browning, Philip		
Specialist	Infectious Disease	Honolulu, Oahu	Bruno, Philip		
Specialist	Hospitalist	Honolulu, Oahu	Bryant, Harold		
Specialist	Hospitalist	Maui	Bush, Terezia		
Specialist	Oncology	Ewa Beach, Oahu	CANCER CENTER OF HAWAII, THE, LLC		
Specialist	Neurology	Honolulu, Oahu	Canonico, Monique		
Specialist	Vascular Surgery	Honolulu, Oahu	Caps, Michael		
Specialist	Oncology	Honolulu, Oahu	Carney, Jennifer		
Specialist	Oncology	Honolulu, Oahu	Chan, Clayton		
Specialist	Cardiology	Honolulu, Oahu	Chan, Stephen		
Specialist	Cardio Vascular	Honolulu, Oahu	Chen, John		
Specialist	Nephrology	Honolulu, Oahu	Chen, Thomas		
Specialist	Physiatry	Honolulu, Oahu	Cheng-Leever, Won-Yee		
Specialist	Peds-Surgery	Honolulu, Oahu	CHILDREN'S SURGERY, LTD		
Specialist	Hospitalist	Honolulu, Oahu	Ching, Catherine		
Specialist	Nephrology	Honolulu, Oahu	Ching, Karen		
Specialist	Neonatology	Honolulu, Oahu	Chiu, Lois		
Specialist	Dermatology	Honolulu, Oahu	Chun, Douglas		
Specialist	Anesthesia	Honolulu, Oahu	Chun, Gerin		
Specialist	Surgery-Cardiothoracic	Honolulu, Oahu	CHUNG, ERIC		
Specialist	Hospitalist	Honolulu, Oahu	Chung, Sze Mei		
Specialist	Neurology	Honolulu, Oahu	Clark, Lee Ann		
Specialist	Infectious Disease	Honolulu, Oahu	Collis, Tarquin		

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Specialist	Neuropsychology	Honolulu, Oahu	Combs, Brian		
Specialist	Emergency Medicine	Honolulu, Oahu	Coor, Colin		
Specialist	Plastic Surgery	Honolulu, Oahu	Crabtree, Thomas		
Specialist	ENT	Maui	CROW, DAVID		
Specialist	Surgery-CV	Honolulu, Oahu	DANG, MICHAEL		
Specialist	Neuropsychology	Honolulu, Oahu	DAVANZO, TANYA		
Specialist	Emergency Medicine	Honolulu, Oahu	Davenport, Douglas		
Specialist	Hospitalist	Maui	Day, Kristi		
Specialist	Peds Pulm	Honolulu, Oahu	Day, Scottie		
Specialist	Gastroenterology	Honolulu, Oahu	Decker, Robert		
Specialist	OB/GYN	Maui	DeLisa, Benjamin		
Specialist	Dermatology	Honolulu, Oahu	Devere, Theresa		
Specialist	Neurology	Honolulu, Oahu	Devere, Todd		
Specialist	Occupational Med	Honolulu, Oahu	DiCostanzo, Joseph		
Specialist	OB/GYN	Waipahu, Oahu	DiMarchi, James		
Specialist	Neurosurgery	Honolulu, Oahu	DONOVAN, DANIEL		
Specialist	Optometry	Waipahu, Oahu	Durham-Worthington, Janice		
Specialist	Hospitalist	Honolulu, Oahu	Dyrud, Martinus		
Specialist	Emergency Medicine	Honolulu, Oahu	EMERGENCY GROUP INC., THE		
Specialist	Emergency Medicine	Honolulu, Oahu	EMERGENCY MEDICAL CARE, INC-EAST		
Specialist	Infectious Disease	Honolulu, Oahu	Eron, Lawrence		
Specialist	Plastic Surgery	Honolulu, Oahu	Faringer, Paul		
Specialist	Podiatry	Honolulu, Oahu	Feria, Antonio		
Specialist	Orthopedic	Maui	Ferrier, James		
Specialist	Ophthalmology	Honolulu, Oahu	Fong, Andrew C		
Specialist	Hospitalist	Honolulu, Oahu	Fong, Janice		
Specialist	Emergency Medicine	Honolulu, Oahu	Ford, James		
Specialist	Dialysis	Honolulu, Oahu	FRESENIUS MEDICAL CARE-ALOHA DIALYSIS CENTER		
Specialist	Dialysis	Honolulu, Oahu	FRESENIUS MEDICAL CARE-HONOLULU DIALYSIS CENTER		

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Specialist	Dialysis	Wahiawa, Oahu	FRESENIUS MEDICAL CARE-WAHIAWA DIALYSIS CENTER		
Specialist	Dialysis	Kaneohe, Oahu	FRESENIUS MEDICAL CARE-WINDWARD DIALYSIS CENTER		
Specialist	Dialysis	Aiea, Oahu	FRESENIUS-PEARLRIDGE DIALYSIS SATELLITE FACILITY		
Specialist	Ped Inpatient	Honolulu, Oahu	Fujinaka, Amy		
Specialist	Gastroenterology	Honolulu, Oahu	Fujiwara, Daryl		
Specialist	Emergency Medicine	Honolulu, Oahu	Fujiwara, David		
Specialist	Occupational Med	Honolulu, Oahu	Gackle, Ronald		
Specialist	Emergency Medicine	Honolulu, Oahu	Gershoff, Leslie		
Specialist	Oncology	Honolulu, Oahu	Ghelani, Dipak		
Specialist	Optometry	Maui	Ginoza, Kim		
Specialist	ITOP	Pearl City, Oahu	Giorgio, Bernard		
Specialist	Optometry	Maui	Glauser, Raymond		
Specialist	Amb Surgery (FP)	Honolulu, Oahu	Glen, Paul		
Specialist	Emergency Medicine	Honolulu, Oahu	Goodman, Torrey		
Specialist	Cardiology	Maui	Gordon, Pamela		
Specialist	Orthopedic	Honolulu, Oahu	Green, Michael		
Specialist	Hospitalist	Honolulu, Oahu	Grieco, Lynne		
Specialist	Peds Pulm	Honolulu, Oahu	Griffith, James		
Specialist	General Surgery	Honolulu, Oahu	Grininger, Lisa		
Specialist	Optometry	Honolulu, Oahu	Gushiken, Roxanne		
Specialist	Emergency Medicine	Kailua, Oahu	HAWAII EMERGENCY PHYSICIANS ASSOCIATED, INC.		
Specialist	Emergency Medicine	Kailua, Oahu	HAWAII EMERGENCY PHYSICIANS ASSOCIATED, INC.		
Specialist	IVF	Honolulu, Oahu	HAWAII REPRODUCTIVE CENTER, INC.		
Specialist	Dermatology-MOHS	Honolulu, Oahu	HAWAII SKIN CANCER AND PHOTODAMAGE CENTER		
Specialist	Vascular Surgery	Honolulu, Oahu	Hayman, Eric		

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Specialist	Hospitalist	Honolulu, Oahu	Henry, Frederick		
Specialist	OB/GYN Inpatient	Honolulu, Oahu	Hirabayashi, Kimie		
Specialist	Obstetrics	Honolulu, Oahu	HIRATA, GREIGH		
Specialist	Cardiology	Honolulu, Oahu	Ho, Paul		
Specialist	Hospitalist	Honolulu, Oahu	Hoak, Dennis		
Specialist	Urology	Maui	Hoekstra, Todd		
Specialist	Pathology	Honolulu, Oahu	Honda, Stacey		
Specialist	Emergency Medicine	Honolulu, Oahu	Honderick, Timothy		
Specialist	Gastroenterology	Honolulu, Oahu	Hong, Kenneth		
Specialist	Oculoplastic Services	Honolulu, Oahu	HONOLULU MEDICAL GROUP, THE		
Specialist	Pain Management	Honolulu, Oahu	HONOLULU PAIN MANAGEMENT CLINIC, LLC		
Specialist	Outpatient Spine Surgery	Honolulu, Oahu	HONOLULU SPINE CENTER, LLC		
Specialist	Geriatrics	Maui	Hope, Pamela		
Specialist	Hospitalist	Maui	Hoskinson, Scott		
Specialist	General Rehabilitation	Honolulu, Oahu	HSIEH, JACK MING-ZU		
Specialist	Ophthalmology	Honolulu, Oahu	Hu, Dean		
Specialist	IVF	Honolulu, Oahu	HUANG, CHRISTOPHER		
Specialist	Podiatry	Maui	Huang, Elly		
Specialist	Continuing Care	Honolulu, Oahu	Hubbard, Carolin		
Specialist	Anesthesia	Honolulu, Oahu	Hultgren, Bruce		
Specialist	OB/GYN	Honolulu, Oahu	Hutchison, Sarah		
Specialist	Ophthalmology	Honolulu, Oahu	Ibarra, Michael		
Specialist	Optometry	Waipahu, Oahu	Ing, Kurt		
Specialist	OB/GYN	Waipahu, Oahu	Inouye-Yamashita, Lori		
Specialist	Pathology	Honolulu, Oahu	Isaacson, Tove		
Specialist	Emergency Medicine	Honolulu, Oahu	Ishida, Jay		
Specialist	Intraoperative Electroneurodiagnostic Services	Honolulu, Oahu	ISLAND NEURODIAGNOSTIC, LLC		

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Specialist	Emergency Medicine	Honolulu, Oahu	ISLANDS EMERGENCY MEDICAL SERVICE, LLC		
Specialist	Surgery-CV	Honolulu, Oahu	ITO, LESLIE		
Specialist	Infertility	Honolulu, Oahu	IVF HAWAII		
Specialist	General Surgery	Honolulu, Oahu	Izawa, Mark		
Specialist	OB/GYN	Maui	Jackson, Jodilana		
Specialist	General Surgery	Maui	Jarrett, Beth		
Specialist	Critical Care	Honolulu, Oahu	Johnson, Christopher		
Specialist	Surgery	Honolulu, Oahu	KAAN, KENNETH		
Specialist	Orthopedic	Honolulu, Oahu	Kahler, James		
Specialist	OB/GYN	Waipahu, Oahu	Kang, Steven		
Specialist	Perinatology	Honolulu, Oahu	KAPIOLANI MEDICAL SPECIALISTS		
Specialist	Optometry	Maui	Kawakami, Kim		
Specialist	Pathology	Honolulu, Oahu	Kaya, Brock		
Specialist	Gastroenterology	Honolulu, Oahu	KAZAMA, RODNEY		
Specialist	Oncology	Maui	Keyes, Ted		
Specialist	Critical Care	Honolulu, Oahu	Khan, Sameena		
Specialist	OB/GYN	Maui	Kim, Michael		
Specialist	Hospitalist	Honolulu, Oahu	Kingsley, Katherine		
Specialist	ENT	Kailua, Oahu	KLEM, CHRISTOPHER		
Specialist	Emergency Medicine	Honolulu, Oahu	Kollai, Eric		
Specialist	OB/GYN	Kailua, Oahu	KOOLAU WOMEN'S HEALTH CARE, INC.		
Specialist	Hospitalist	Honolulu, Oahu	Koopmann, Sarah		
Specialist	Continuing Care	Honolulu, Oahu	Kop, Arnold		
Specialist	Urology	Honolulu, Oahu	Kristo, Blaine		
Specialist	Emergency Medicine	Honolulu, Oahu	KUAKINI EMERGENCY PHYSICIANS SERVICE, LLC		
Specialist	Hospitalist	Honolulu, Oahu	Kulia, Ben		
Specialist	Cardiology	Honolulu, Oahu	Kwaku, Kevin		
Specialist	Hospitalist	Honolulu, Oahu	Larsen, Kristin		
Specialist	Nephrology	Honolulu, Oahu	Lau, Alan		

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Specialist	Dermatology	Honolulu, Oahu	Lau, Bradley		
Specialist	Surgery-CV	Honolulu, Oahu	LAU, JEFFREY		
Specialist	Allergy	Honolulu, Oahu	Lau, Matthew		
Specialist	OB/GYN	Kailua, Oahu	Lawrence, Melissa		
Specialist	Nephrology	Honolulu, Oahu	Lee, Brian		
Specialist	Gastroenterology	Aiea, Oahu	LEE, DARRELL		
Specialist	Cardio Vascular	Honolulu, Oahu	Lee, John		
Specialist	Optometry	Waipahu, Oahu	Lem, Lydia		
Specialist	Occupational Med	Maui	Lenny, Paula		
Specialist	Cardiology	Honolulu, Oahu	Leung, Cyril		
Specialist	OB/GYN	Honolulu, Oahu	LI, GAYLYN		
Specialist	Dialysis	Honolulu, Oahu	LIBERTY DIALYSIS-HAWAII LLC		
Specialist	Dialysis	Maui	LIBERTY-KAHANA DIALYSIS SATELLITE FACILITY		
Specialist	Dialysis	Ewa Beach, Oahu	LIBERTY-LEEWARD DIALYSIS SATELLITE FACILITY		
Specialist	Dialysis	Maui	LIBERTY-MAUI DIALYSIS SATELLITE FACILITY		
Specialist	Dialysis	Honolulu, Oahu	LIBERTY-SIEMSEN DIALYSIS SATELLITE FACILITY		
Specialist	Dialysis	Waianae, Oahu	LIBERTY-WAIANAE DIALYSIS SATELLITE FACILITY		
Specialist	Neurosurgery	Honolulu, Oahu	LIEM, LEON		
Specialist	Hospitalist	Honolulu, Oahu	Lim, Sue		
Specialist	General Rehabilitation	Honolulu, Oahu	LIN, DWIGHT		
Specialist	Optometry	Honolulu, Oahu	Ling, Ronald		
Specialist	ENT	Honolulu, Oahu	Liu, Alfred		
Specialist	Endocrinology	Honolulu, Oahu	Loh, Jennifer		
Specialist	Pathology	Honolulu, Oahu	Loo, Stanley		
Specialist	Occupational Med	Waipahu, Oahu	Lum, Peter		
Specialist	Hospitalist	Maui	Martin, Ronald		
Specialist	Continuing Care	Honolulu, Oahu	Matayoshi, Aleza		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	General Surgery	Honolulu, Oahu	Matayoshi, Eric		
Specialist	Orthopedic	Honolulu, Oahu	Mathews, David		
Specialist	Pathology	Honolulu, Oahu	Matsuura Eaves, Jodi		
Specialist	Pediatric Pulmonary	Honolulu, Oahu	MATTHEWS, WALLACE		
Specialist	Hospitalist	Honolulu, Oahu	Mau, Monica		
Specialist	Cardiology	Maui	MAUI CARDIOLOGY, LTD.		
Specialist	Sleep Study	Maui	MAUI CHEST MEDICINE		
Specialist	Nephrology	Maui	MAUI NEPHROLOGY, LLC		
Specialist	Oral & Maxillofacial Surgery	Maui	MAUI ORAL SURGERY, LLC		
Specialist	Cosmetic Dermatology	Honolulu, Oahu	Maurice, Dorothy		
Specialist	Ophthalmology	Honolulu, Oahu	McCann, David		
Specialist	ENT	Honolulu, Oahu	McKenney, Mark		
Specialist	Pain Mgmt	Honolulu, Oahu	McKoy, James		
Specialist	General Surgery	Honolulu, Oahu	McPherson, Lori		
Specialist	Nephrology	Maui	Mendoza, Susana		
Specialist	Cardiology	Honolulu, Oahu	Merchant, Ali		
Specialist	Geriatrics	Honolulu, Oahu	Minaai, Dawn		
Specialist	Optometry	Honolulu, Oahu	Mirikitani, Irene		
Specialist	Dermatology	Honolulu, Oahu	Mita, Randall		
Specialist	OB/GYN	Honolulu, Oahu	Miura, Christopher		
Specialist	Physiatry	Honolulu, Oahu	Miura-Akamine, Merle		
Specialist	Anesthesia	Honolulu, Oahu	Miyagi, Jon		
Specialist	Anesthesia	Honolulu, Oahu	Miyahara, Cary		
Specialist	Hospitalist	Honolulu, Oahu	Moen, Zamir		
Specialist	Peds-Cardiology	Honolulu, Oahu	MORENO-CABRAL, CARLOS		
Specialist	Orthopedics	Honolulu, Oahu	MORI, HAYATO		
Specialist	Neurosurgery	Honolulu, Oahu	MORITA, MICHON		
Specialist	Orthopedic	Honolulu, Oahu	Moritz, Burt		
Specialist	General Surgery	Honolulu, Oahu	Morris, Chenoa		
Specialist	Hospitalist	Honolulu, Oahu	Mruthyunjayanna, Vikram		
Specialist	Optometry	Waipahu, Oahu	Mueller, Gregory		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	Orthopedic Surgery	Honolulu, Oahu	MURRAY, PATRICK		
Specialist	Nephrology	Honolulu, Oahu	NADA, ONO, KA'ANEHE, LLP		
Specialist	Gastroenterology	Honolulu, Oahu	NAGAMORI, KEN		
Specialist	Surgery-CV	Honolulu, Oahu	NAKAMURA, DEAN		
Specialist	Optometry	Honolulu, Oahu	Nakamura, Dulcianne		
Specialist	OB/GYN Inpatient	Honolulu, Oahu	Nakamura-Tanoue, Joyce		
Specialist	Continuing Care	Honolulu, Oahu	Nakatsuka, Craig		
Specialist	ENT	Honolulu, Oahu	Napier, Bradford		
Specialist	Vascular Surgery	Honolulu, Oahu	Nelken, Nicolas		
Specialist	OB/GYN	Maui	Newman, Martin		
Specialist	ENT	Maui	Newman, Scott		
Specialist	Oncology	Honolulu, Oahu	Nguyen, Huy		
Specialist	Cardiology	Honolulu, Oahu	Nguyen, Marie		
Specialist	Plastic Surgery	Honolulu, Oahu	Nishikawa, Scott		
Specialist	Ophthalmology	Honolulu, Oahu	Nishimura, Julie		
Specialist	Optometry	Honolulu, Oahu	Noblezada, Johnny		
Specialist	Orthopedic	Honolulu, Oahu	Null, Robert		
Specialist	Eating Disorders	Honolulu, Oahu	NUTRITION THERAPY CONSULTANTS, INC.		
Specialist	OB/GYN	Honolulu, Oahu	Ogasawara, Keith		
Specialist	OB/GYN	Kaneohe, Oahu	Ogasawara-Chun, Eileen		
Specialist	Emergency Medicine	Honolulu, Oahu	Olkowski, Tina		
Specialist	Optometry	Kailua, Oahu	Onizuka, Homer		
Specialist	Nephrology	Honolulu, Oahu	ONO, DAVID		
Specialist	Surgery-Oral	Honolulu, Oahu	ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, INC.		
Specialist	Hospitalist	Honolulu, Oahu	Orimoto, Steven		
Specialist	Surgery-Orthopedic	Honolulu, Oahu	ORTHOPEDIC ASSOCIATES OF HAWAII, LLP		
Specialist	Peds-ICU	Honolulu, Oahu	OTTO, CAROL		
Specialist	Emergency Medicine	Honolulu, Oahu	PACIFIC EMERGENCY PHYSICIANS, LLC		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	OB/GYN-Fertilization	Honolulu, Oahu	PACIFIC IN VITRO FERTILIZATION INSTITUTE		
Specialist	Nephrology	Maui	PACIFIC NEPHROLOGY, LLC		
Specialist	Sleep Disorder and Pulmonary	Honolulu, Oahu	PACIFIC SLEEP TECH, INC.		
Specialist	ENT	Honolulu, Oahu	Pang, Richard		
Specialist	Neurology	Honolulu, Oahu	Pang, Stuart		
Specialist	Cardiology	Honolulu, Oahu	Parikh, Nisha		
Specialist	Physiatry	Honolulu, Oahu	Patten, Maria		
Specialist	Peds-Anesthesiology	Honolulu, Oahu	PI, MICHAEL		
Specialist	Ped Inpatient	Honolulu, Oahu	Piette, Martin		
Specialist	OB/GYN-ITOP	Honolulu, Oahu	PLANNED PARENTHOOD OF HAWAII		
Specialist	OB/GYN-ITOP	Honolulu, Oahu	PLANNED PARENTHOOD OF HAWAII		
Specialist	OB/GYN-ITOP	Honolulu, Oahu	PLANNED PARENTHOOD OF HAWAII		
Specialist	Optometry	Honolulu, Oahu	Prigge, Emil		
Specialist	Dermatology	Honolulu, Oahu	Putnam, Francis		
Specialist	Emergency Medicine	Honolulu, Oahu	Quan, Perri		
Specialist	ENT	Honolulu, Oahu	RAMSEY, MITCHELL		
Specialist	Surgery-Oral	Maui	RASMUSSEN, RICHARD		
Specialist	Dermatology	Maui	Reisenauer, Amy		
Specialist	Optometry	Honolulu, Oahu	Remillard, Jan		
Specialist	Surgery-Retinal	Aiea, Oahu	RETINA CONSULTANTS OF HAWAII		
Specialist	Surgery-Retinal	Honolulu, Oahu	RETINA INSTITUTE OF HAWAII		
Specialist	Orthopedic	Honolulu, Oahu	Reyes, Michael		
Specialist	Pathology	Honolulu, Oahu	Rios, Carlos		
Specialist	OB/GYN	Maui	Rogers, Nancy		
Specialist	General Surgery	Maui	Romanchak, Dorien		
Specialist	Hospitalist	Honolulu, Oahu	Rowe, Robert		
Specialist	General Radiology	Honolulu, Oahu	RUESS, LYNNE		
Specialist	Emergency Medicine	Honolulu, Oahu	Russell, Laura		
Specialist	Emergency Medicine	Honolulu, Oahu	Russell, Saba		
Specialist	Physiatry	Honolulu, Oahu	Saito, Coswin		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	General Surgery	Maui	Sakai, Leonard		
Specialist	Neurology	Honolulu, Oahu	Sakurai, Sharin		
Specialist	Non-Medical Detoxification	Honolulu, Oahu	SALVATION ARMY ADDICTION TREATMENT SERVICES, THE		
Specialist	Orthopedic	Honolulu, Oahu	Sandoval, Carlos		
Specialist	Orthopedic	Honolulu, Oahu	Santi, Mark		
Specialist	Anesthesia	Honolulu, Oahu	Saruwatari, Jonn		
Specialist	General Surgery	Honolulu, Oahu	Sawai, Rebecca		
Specialist	Optometry	Maui	Schiessler, Daniel		
Specialist	Vascular Surgery	Honolulu, Oahu	Schneider, Peter		
Specialist	Neurosurgery	Honolulu, Oahu	Schnitzer, Mark		
Specialist	Continuing Care	Honolulu, Oahu	Seitz, Rae		
Specialist	Orthopedic	Honolulu, Oahu	Shaieb, Mark		
Specialist	Geriatrics	Honolulu, Oahu	Sharma, Kavita		
Specialist	Pain Mgmt	Honolulu, Oahu	Sheehan, John		
Specialist	Cardiology	Honolulu, Oahu	SHEN, EDWARD		
Specialist	Ped Inpatient	Honolulu, Oahu	Shibao, Stacie		
Specialist	Orthopedic	Honolulu, Oahu	Shin, Robert		
Specialist	Pediatric Cardiology	Honolulu, Oahu	Shirai, Lance		
Specialist	Urology	Maui	Shurtleff, Benjamin		
Specialist	OB/GYN	Honolulu, Oahu	Sisler, Jonathan		
Specialist	Hospitalist	Honolulu, Oahu	Skovrinski, Timothy		
Specialist	Sleep Medicine	Pearl City, Oahu	SLEEP CENTER HAWAII LLC		
Specialist	Occupational Med	Waipahu, Oahu	Smith, Paul		
Specialist	Nutrition Therapy	Kailua, Oahu	SMITH-OSWALD, DARYL		
Specialist	ENT	Honolulu, Oahu	Sniezek, Joseph		
Specialist	Ophthalmology	Waipahu, Oahu	Soneda, Cynthia		
Specialist	ENT	Maui	Song, Alan		
Specialist	General & Neurointerventional Radiology	Honolulu, Oahu	SONG, FELIX		
Specialist	OB/GYN	Waipahu, Oahu	Song, Tricia		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	Hospitalist	Maui	Stewart, Susan		
Specialist	Surgery-CV	Honolulu, Oahu	STRAUB CLINIC & HOSPITAL, INC.		
Specialist	Emergency Medicine	Honolulu, Oahu	Strongosky, Gregory		
Specialist	OB/GYN	Waipahu, Oahu	Sueda, Alexandra		
Specialist	OB/GYN	Honolulu, Oahu	Sunoo, Christian		
Specialist	Post-liver/Post -kidney visit and management	Honolulu, Oahu	SURGICAL ASSOCIATES, INC.		
Specialist	Anesthesiology-Open Heart	Honolulu, Oahu	Suyama, Alan		
Specialist	Emergency Medicine	Honolulu, Oahu	Szasz, Mark		
Specialist	Occupational Med	Honolulu, Oahu	Tadaki, Stella		
Specialist	General Surgery	Honolulu, Oahu	Takamori, Ryan		
Specialist	Pulmonology	Honolulu, Oahu	Takaoka, Shanon		
Specialist	Dermatology	Honolulu, Oahu	Takiguchi, Rodd		
Specialist	Emergency Medicine	Honolulu, Oahu	Tam Sing, Kelly		
Specialist	Pulmonology	Honolulu, Oahu	Tamamoto, Warren		
Specialist	Ocularist	Honolulu, Oahu	TANCO, LLC		
Specialist	Ophthalmology	Maui	Taylor, Bruce		
Specialist	Physiatry	Maui	Teoh, Talent		
Specialist	Ophthalmology	Honolulu, Oahu	Tham, Vivien		
Specialist	Neurosurgery	Honolulu, Oahu	THOMPSON, TODD		
Specialist	Cardiology	Maui	Tillinghast, Stanley		
Specialist	Geriatrics	Honolulu, Oahu	Tokushige Pang, Liane		
Specialist	Hospitalist	Honolulu, Oahu	Tom, Richard		
Specialist	Nephrology	Honolulu, Oahu	Tomita, B		
Specialist	Ped Inpatient	Honolulu, Oahu	Tran, Anne		
Specialist	Peds-ENT	Honolulu, Oahu	TRAN, LENHANH		
Specialist	Anesthesia	Honolulu, Oahu	Trinh, Tham		
Specialist	Gastroenterology	Honolulu, Oahu	Tsushima, Matthew		
Specialist	Hospitalist	Honolulu, Oahu	Turner, Anthony		
Specialist	Anesthesia	Honolulu, Oahu	Ueunten, David		
Specialist	Sports Medicine	Honolulu, Oahu	Uhr, Frank		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	Critical Care	Honolulu, Oahu	Umbarger, Lillian		
Specialist	Maternal & Fetal Medicine	Honolulu, Oahu	UNIVERSITY CLINICAL, EDUCATION AND RESEARCH ASSOCIATION		
Specialist	Peds-Endocrinology	Honolulu, Oahu	URAMOTO, GREG		
Specialist	Occupational Med	Honolulu, Oahu	Van Meter, Jerry		
Specialist	Orthopedic	Honolulu, Oahu	Vasconcellos, David		
Specialist	ENT	Honolulu, Oahu	Vassalli, Luca		
Specialist	Laser Eye Surgery	Honolulu, Oahu	Wang, Shao-Ling		
Specialist	Urology	Honolulu, Oahu	Washecka, Robert		
Specialist	Ophthalmology	Honolulu, Oahu	Waters, David		
Specialist	Pediatric Endocrinology	Honolulu, Oahu	WAXMAN, SORRELL		
Specialist	Hospitalist	Honolulu, Oahu	White, Samuel		
Specialist	OB/GYN	Honolulu, Oahu	White, Terry		
Specialist	Surgery-Oral	Honolulu, Oahu	WILHITE, STEVEN		
Specialist	Hospitalist	Maui	Williams, David		
Specialist	Orthopedic	Maui	Wirsing, Kimberley		
Specialist	OB/GYN	Honolulu, Oahu	Wong, Abbielyn		
Specialist	General Surgery	Honolulu, Oahu	Wong, Brian		
Specialist	Podiatry	Honolulu, Oahu	Wong, Earl		
Specialist	Orthopedic	Honolulu, Oahu	Wong, Grace		
Specialist	OB/GYN	Honolulu, Oahu	Wong, Mabel		
Specialist	Gastroenterology	Aiea, Oahu	WONG, ROBERT		
Specialist	Geriatrics	Honolulu, Oahu	Wong, Warren		
Specialist	Cardio Vascular	Honolulu, Oahu	Wu, Jeffrey		
Specialist	Hospitalist	Honolulu, Oahu	Yamagata, Zelah		
Specialist	General Surgery	Honolulu, Oahu	Yamamura, Mark		
Specialist	Hospitalist	Honolulu, Oahu	Yamashita, Shellie		
Specialist	OB/GYN	Kaneohe, Oahu	Yanagisawa, Randal		
Specialist	Dermatology	Honolulu, Oahu	Yang, Deborah		
Specialist	Hospitalist	Honolulu, Oahu	Yates, Jaelene		
Specialist	Urogynecology	Honolulu, Oahu	Yee, Aileen		
Specialist	General Surgery	Honolulu, Oahu	Yee, Betty		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Specialist	Peds-Neurology	Honolulu, Oahu	YIM, GREGORY		
Specialist	Hospitalist	Honolulu, Oahu	Yim, Kelley		
Specialist	Continuing Care	Honolulu, Oahu	Yim, Lester		
Specialist	Gastroenterology	Honolulu, Oahu	Yoshida, Mark		
Specialist	Hospitalist	Honolulu, Oahu	Young, Glenn		
Specialist	Optometry	Honolulu, Oahu	Young, Gregory		
Specialist	Optometry	Waipahu, Oahu	Young, Kaylin		
Specialist	Rheumatology	Honolulu, Oahu	Zane, Janice		
Hospital	Hospital	Kailua, Oahu	CASTLE MEDICAL CENTER		
Hospital	Emergency Medicine	Ewa Beach, Oahu	EMERGENCY MEDICAL CARE, INC-WEST		
Hospital	Hospital	Honolulu, Oahu	HAWAII HEALTH SYSTEMS CORPORATION (HHSC)		
Hospital	Hospital & SNF	Honolulu, Oahu	HAWAII MEDICAL CENTER EAST		
Hospital	Hospital & SNF	Ewa Beach, Oahu	HAWAII MEDICAL CENTER WEST		
Hospital	Hospital	Kahuku, Oahu	KAHUKU MEDICAL CENTER		
Hospital	Hospital & SNF/ICF	Honolulu, Oahu	Kaiser Moanalua Medical Center		
Hospital	Hospital	Honolulu, Oahu	KAPIOLANI MEDICAL CENTER @ PALI MOMI		
Hospital	Hospital	Honolulu, Oahu	KAPIOLANI MEDICAL CENTER FOR WOMEN & CHILDREN		
Hospital	Hospital	Honolulu, Oahu	KUAKINI MEDICAL CENTER		
Hospital	Hospital	Maui	KULA HOSPITAL		
Hospital	Hospital	Honolulu, Oahu	LEAHI HOSPITAL		
Hospital	Hospital & SNF	Honolulu, Oahu	MALUHIA HOSPITAL		
Hospital	Hospital & SNF/ICF	Maui	MAUI MEMORIAL MEDICAL CENTER		
Hospital	Hospital & SNF	Honolulu, Oahu	QUEEN'S MEDICAL CENTER, THE		
Hospital	Hospital	Honolulu, Oahu	STRAUB CLINIC & HOSPITAL		
Hospital	Hospital & SNF	Wahiawa, Oahu	WAHIAWA GENERAL HOSPITAL		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Emergency Transport	Air Ambulance Transports	Honolulu, Oahu	AIRMED HAWAII, LLC		
Emergency Transport	Transport	Aiea, Oahu	AMERICAN MEDICAL RESPONSE		
Emergency Transport	Transport-Air ambulance (inter-island)	Honolulu, Oahu	HAWAII LIFEFLIGHT, LLC		
Emergency Transport	Emergency Medical Transport	Honolulu, Oahu	STATE OF HAWAII EMS		
Pharmacy		Laie, Oahu	Foodland Pharmacy - Laie		
Pharmacy		Honolulu, Oahu	KAISER MOANALUA MEDICAL CENTER		
Pharmacy		Honolulu, Oahu	Kaiser Permanente Hawaii – Hawaii Kai Clinic		
Pharmacy		Honolulu, Oahu	Kaiser Permanente Hawaii - Honolulu Clinic		
Pharmacy		Kahuku, Oahu	Kaiser Permanente Hawaii - Kahuku Clinic		
Pharmacy		Kailua, Oahu	Kaiser Permanente Hawaii - Kailua Clinic		
Pharmacy		Kapolei, Oahu	Kaiser Permanente Hawaii - Kapolei Clinic		
Pharmacy		Maui	Kaiser Permanente Hawaii - Kihei Clinic		
Pharmacy		Kaneohe, Oahu	Kaiser Permanente Hawaii - Koolau Clinic		
Pharmacy		Maui	Kaiser Permanente Hawaii - Lahaina Clinic		
Pharmacy		Honolulu, Oahu	Kaiser Permanente Hawaii - Mapunapuna Clinic		
Pharmacy		Maui	Kaiser Permanente Hawaii – Maui Lani Clinic		
Pharmacy		Waianae, Oahu	Kaiser Permanente Hawaii - Nanaikeola Clinic		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Pharmacy		Maui	Kaiser Permanente Hawaii – Wailuku Clinic		
Pharmacy		Waipahu, Oahu	Kaiser Permanente Hawaii – Waipio Clinic		
Pharmacy		Honolulu, Oahu	Longs Drugs - Ala Moana		
Pharmacy		Honolulu, Oahu	Longs Drugs - Downtown Bishop		
Pharmacy		Ewa Beach, Oahu	Longs Drugs - Ewa Beach		
Pharmacy		Ewa Beach, Oahu	Longs Drugs - Ewa Beach		
Pharmacy		Honolulu, Oahu	Longs Drugs - Gulick		
Pharmacy		Maui	Longs Drugs - Kihei		
Pharmacy		Maui	Longs Drugs - Maui Mall		
Pharmacy		Honolulu, Oahu	Longs Drugs - Pali		
Pharmacy		Kapolei, Oahu	Mina Pharmacy - Kapolei		
Pharmacy		Honolulu, Oahu	PHARMACY CORP. OF AMERICA / IPC PHARMACIES		
Laboratory		Ewa Beach, Oahu	CLINICAL LABORATORIES OF HAWAII, LLP		
Laboratory		Maui	CLINICAL LABORATORIES OF HAWAII, LLP		
Laboratory		Aiea, Oahu	DIAGNOSTIC LABORATORY SERVICES, INC.		
Laboratory		Honolulu, Oahu	Kaiser Permanente Hawaii – Hawaii Kai Clinic		
Laboratory		Honolulu, Oahu	Kaiser Permanente Hawaii - Honolulu Clinic		
Laboratory		Kahuku, Oahu	Kaiser Permanente Hawaii - Kahuku Clinic		
Laboratory		Kailua, Oahu	Kaiser Permanente Hawaii - Kailua Clinic		
Laboratory		Kapolei, Oahu	Kaiser Permanente Hawaii - Kapolei Clinic		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Laboratory		Maui	Kaiser Permanente Hawaii - Kihei Clinic		
Laboratory		Kaneohe, Oahu	Kaiser Permanente Hawaii - Koolau Clinic		
Laboratory		Maui	Kaiser Permanente Hawaii - Lahaina Clinic		
Laboratory		Honolulu, Oahu	Kaiser Permanente Hawaii - Mapunapuna Clinic		
Laboratory		Maui	Kaiser Permanente Hawaii – Maui Lani Clinic		
Laboratory		Waianae, Oahu	Kaiser Permanente Hawaii - Nanaikeola Clinic		
Laboratory		Maui	Kaiser Permanente Hawaii – Wailuku Clinic		
Laboratory		Waipahu, Oahu	Kaiser Permanente Hawaii – Waipio Clinic		
Radiology	INV/INTV	Honolulu, Oahu	Abcarian, Peter		
Radiology	Open MRI	Aiea, Oahu	ACCUIMAGING		
Radiology	Radiation Therapy	Maui	Baker, Bobby		
Radiology	General	Honolulu, Oahu	Broadfoot, Rickie		
Radiology	Radiology	Honolulu, Oahu	Burton, Bradford		
Radiology	Radiosurgery	Honolulu, Oahu	GAMMA KNIFE CENTER OF THE PACIFIC		
Radiology	PET MRI	Honolulu, Oahu	HAWAII PET IMAGING, LLC		
Radiology	General	Honolulu, Oahu	Henshaw, Daniel		
Radiology	GI Readings	Honolulu, Oahu	HIATT, GERALD A., MD		
Radiology	General	Honolulu, Oahu	Hong, Steven		
Radiology	Radiology	Honolulu, Oahu	ISLAND IMAGING CENTER, LLC		
Radiology	General	Honolulu, Oahu	Kennedy, Katrena		
Radiology	General	Honolulu, Oahu	Mahon, Thomas		
Radiology	Radiology	Honolulu, Oahu	MAUI DIAGNOSTIC IMAGING, LLC		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Radiology	General	Maui	Miyasato, Lee		
Radiology	General	Honolulu, Oahu	Moy, Mitchell		
Radiology	General	Honolulu, Oahu	Nishimura, Earl		
Radiology	Radiation Therapy	Honolulu, Oahu	PACIFIC RADIATION ONCOLOGY, LLC		
Radiology	Radiology	Honolulu, Oahu	RADIOLOGY ASSOCIATES, INC.		
Radiology	General	Honolulu, Oahu	Rafto, Stein		
Radiology	Radiology	Honolulu, Oahu	Shibuya, Alison		
Radiology	INV/INTV	Honolulu, Oahu	Watabe, John		
Radiology	Echo Technician	Maui	WILLIAMS BS RDCS LLC, TAMMY L		
Radiology	INV/INTV	Honolulu, Oahu	Wu, Samuel		
Radiology	Diagnostic Radiology	Honolulu, Oahu	YEOH AND MURANAKA MD, INC.		
Radiology	General	Honolulu, Oahu	Yoon, Hyo-Chun		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Honolulu, Oahu	BALANCE CENTERS OF THE PACIFIC, INC		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical & Occupational Therapy	Honolulu, Oahu	CHANG, JASON		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Honolulu, Oahu	CHIANG, TON MING		
Physical, Occupational, Audiology, Speech and Language Therapy	Occupational Therapy/Speech	Honolulu, Oahu	HAWAII PROFESSIONAL AUDIOLOGY		
Physical, Occupational, Audiology, Speech and Language Therapy	Audiology	Honolulu, Oahu	ISLAND AUDIOLOGY, LLC.		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Honolulu, Oahu	Kaiser Permanente Hawaii - Honolulu Clinic		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Maui	Kaiser Permanente Hawaii - Kihei Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Kaneohe, Oahu	Kaiser Permanente Hawaii - Koolau Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Maui	Kaiser Permanente Hawaii - Lahaina Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical, Occupational & Speech Therapy	Honolulu, Oahu	Kaiser Permanente Hawaii - Mapunapuna Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical, Occupational & Speech Therapy	Maui	Kaiser Permanente Hawaii – Wailuku Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical & Occupational Therapy	Waipahu, Oahu	Kaiser Permanente Hawaii – Waipio Clinic		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical & Occupational Therapy	Maui	LAHAINA PHYSICAL THERAPY		
Physical, Occupational, Audiology, Speech and Language Therapy	Rehab Hospital	Maui	MAUI CENTER FOR CHILD DEVELOPMENT		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Honolulu, Oahu	NOMURA, RYAN		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Honolulu, Oahu	OSHIRO, SHARI ANN		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Maui	PHYSICAL THERAPY SERVICES OF HANA		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Kailua, Oahu	PO'AILANI, INC.		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Therapy	Honolulu, Oahu	REHABILITATION HOSPITAL OF THE PACIFIC		
Physical, Occupational, Audiology, Speech and Language Therapy	Audiology	Honolulu, Oahu	RUTH, MARYLEE		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical & Occupational Therapy	Honolulu, Oahu	Somal, Amendeep		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical & Occupational Therapy	Maui	THERAPEUTIC ASSOCIATES OF MAUI, LLC		
Physical, Occupational, Audiology, Speech and Language Therapy	Audiology	Honolulu, Oahu	UYEHARA-ISONO, JUNE		
Physical, Occupational, Audiology, Speech and Language Therapy	Physical Medicine & Rehabilitation	Honolulu, Oahu	YAMAMOTO, KENT		
Behavioral Health	Psychology	Kaneohe, Oahu	ADAPTIVE BEHAVIOR CHANGE CONSULTANTS		
Behavioral Health	Psychology	Maui	ARCHIBEQUE, T. NALANI		
Behavioral Health	Psychiatry	Maui	Arensdorf, Alfred		
Behavioral Health	Behavioral Health	Waipahu, Oahu	Bell, Cathy		
Behavioral Health	Psychiatry	Maui	BETWEE, JON		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Behavioral Health	Chemical Dependency Rehab	Kahuku, Oahu	BOBBY BENSON CENTER		
Behavioral Health	Psychology	Maui	BREITHAUPT, MARK		
Behavioral Health	Psychology	Maui	CARINGER, ELLEN		
Behavioral Health	Psychiatry	Honolulu, Oahu	CLINICAL AND COUNSELING PSYCHOLOGY, LLC		
Behavioral Health	Psych & CD Rehab	Honolulu, Oahu	COMMUNITY EMPOWERMENT SERVICES		
Behavioral Health	Chemical Dependency Rehab	Honolulu, Oahu	COMPREHENSIVE HEALTH&ATTITUDE MGMT PROGRAM INC.		
Behavioral Health	Chemical Dependency Rehab	Maui	COMPREHENSIVE HEALTH&ATTITUDE MGMT PROGRAM INC.		
Behavioral Health	Psychology	Honolulu, Oahu	CYNN, VIRGINIA		
Behavioral Health	Behavioral Health	Maui	Draeger, John		
Behavioral Health	Psychology	Maui	FRIEDMAN, GEORGE		
Behavioral Health	Behavioral Health	Honolulu, Oahu	Gadam, Samuel		
Behavioral Health	Psychology	Honolulu, Oahu	HARTWELL THERAPY & CONSULTING, LLC		
Behavioral Health	Behavioral Health	Honolulu, Oahu	HAWAII CENTER FOR PSYCHOLOGY		
Behavioral Health	Psychiatry	Honolulu, Oahu	HELPING HANDS HAWAII		
Behavioral Health	Chemical Dependency	Kaneohe, Oahu	HINA MAUKA ALCOHOLIC REHABILITATION SERVICES		
Behavioral Health	Chemical Dependency	Kaneohe, Oahu	HINA MAUKA ALCOHOLIC REHABILITATION SERVICES		
Behavioral Health	Psychology	Honolulu, Oahu	HORTON, JAMIE		
Behavioral Health	Psychology	Honolulu, Oahu	JAQUES, LYNDA		
Behavioral Health	Behavioral Health	Ewa Beach, Oahu	KAHI MOHALA		
Behavioral Health	Psychology	Honolulu, Oahu	KEAST, KRISTIN		
Behavioral Health	Psychiatry	Honolulu, Oahu	KUSAKA, YUKO		
Behavioral Health	Psychology	Honolulu, Oahu	LAMPORT-HUGHES, NANCY		
Behavioral Health	Behavioral Health	Honolulu, Oahu	LIFEFORCE, INC.		
Behavioral Health	Psychology	Honolulu, Oahu	LOOS, WARREN		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Behavioral Health	Behavioral Health	Maui	Mathews, Michael		
Behavioral Health	Psychology	Maui	MAUI BEHAVIORAL HEALTH SERVICES, INC.		
Behavioral Health	Behavioral Health	Honolulu, Oahu	McCanless, Michael		
Behavioral Health	Behavioral Health	Honolulu, Oahu	Melendrez-Chu, Tina		
Behavioral Health	Behavioral Health	Honolulu, Oahu	MENTAL HEALTH KOKUA		
Behavioral Health	Psychology	Honolulu, Oahu	O'NEAL, SCOTT		
Behavioral Health	Psychiatry	Kailua, Oahu	PLAY THERAPY CENTER OF HAWAII, LLC		
Behavioral Health	Psychology	Honolulu, Oahu	SINE, LARRY		
Behavioral Health	Psych Hospital & CD Rehab	Honolulu, Oahu	SMITH, DOUGLAS		
Behavioral Health	Psychology	Ewa Beach, Oahu	ST. FRANCIS HOME CARE SERVICES		
Behavioral Health	Psychology	Honolulu, Oahu	STRAUSS, MARILYN		
Behavioral Health	Behavioral Health	Waipahu, Oahu	Teraoka, Scott		
Behavioral Health	Psychiatry	Kailua, Oahu	THOMPSON, DAVID		
Behavioral Health	Psychiatry	Honolulu, Oahu	THOUGHT FIELD THERAPY, INC.		
Behavioral Health	Psychology	Honolulu, Oahu	TILLICH, RENE		
Behavioral Health	Psychiatry (Child Psychiatric Nursing)	Honolulu, Oahu	VAJDA, EDITH		
Behavioral Health	Psychology	Honolulu, Oahu	VOGELMANN-SINE, SILKE		
Behavioral Health	Psychology	Honolulu, Oahu	WETZEL, ROB		
Behavioral Health	Behavioral Health	Honolulu, Oahu	Yee, Yulee		
Home Health Agency & Hospice	Home Health Agency	Honolulu, Oahu	BRISTOL HOSPICE - HAWAII LLC		
Home Health Agency & Hospice	Home Health Agency	Kaneohe, Oahu	CASTLE HOME CARE SERVICES		
Home Health Agency & Hospice	Home Health Agency	Maui	HALE MAKUA HOME HEALTH CARE AGENCY		
Home Health Agency & Hospice	Hospice	Honolulu, Oahu	HOSPICE HAWAII, INC.		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Home Health Agency & Hospice	Hospice	Maui	HOSPICE MAUI, INC.		
Home Health Agency & Hospice	Home Health Agency	Honolulu, Oahu	Kaiser Permanente Home Health Agency		
Home Health Agency & Hospice	Home Health Agency	Honolulu, Oahu	KOKUA NURSES		
Home Health Agency & Hospice	Hospice	Honolulu, Oahu	ST. FRANCIS HOSPICE		
Home Health Agency & Hospice	Home Health Agency	Ewa Beach, Oahu	ST. FRANCIS HOSPICE WEST		
Home Health Agency & Hospice	Hospice				
Durable Medical Equipment and Medical Suppliers	DME and Prosthetics	Honolulu, Oahu	ADVANCED PROSTHETICS AND ORTHOTICS OF THE PACIFIC		
Durable Medical Equipment and Medical Suppliers	DME (Prosthesis & Orthotics)	Honolulu, Oahu	C.R. NEWTON		
Durable Medical Equipment and Medical Suppliers	DME	Honolulu, Oahu	HONOLULU ORTHOPEDIC SUPPLY, INC.		
Durable Medical Equipment and Medical Suppliers	DME (Breast Prostheses)	Honolulu, Oahu	ME AGAIN! INC.		
Durable Medical Equipment and Medical Suppliers	DME (Breast Prosthesis and surgical bras)	Honolulu, Oahu	NORDSTROM		
Durable Medical Equipment and Medical Suppliers	DME	MAUI	GAMMIE HOMECARE, INC.		
Non-Emergency Transportatio	Transport-Patient (non-emergency)	Honolulu, Oahu	HANDICABS OF THE PACIFIC		
Non-Emergency Transportatio	Gurney & Wheelchair Transport	Kaneohe, Oahu	PONO TRANSPORT, INC.		
Interpretation/Translation	Interpretation	Oahu	Bilingual Access Line		

Provider Type	Specialty	Island/County (for Oahu include the city)	Provider Name (Last Name, First Name, Middle Initial)	Accepting New QUEST members (Y/N)?	Any limits on QUEST members? (Y/N)?
Interpretation/Translation	Interpretation	Oahu	Brocula Palsis		
Interpretation/Translation	Written Translation	Oahu/Maui	Global Solutions		
Interpretation/Translation	American Sign Language	Oahu/Maui	Hawaii Interpreting Services		
Interpretation/Translation	Telephone Interpretation	Oahu/Maui	Language Line Services		
Interpretation/Translation	Interpretation	Maui	Maui Economic Opportunity, Inc (Enlace Hispano Program)		
Interpretation/Translation	Interpretation	Oahu	Pacific Gateway Center		
Interpretation/Translation	Telephone Interpretation	Oahu/Maui	Pacific Interpreters		
Interpretation/Translation	Interpretation	Maui	Phyllis Hernandez		

Acute Care Hospital Locations

Kaiser Foundation Health Plan, Inc. - Hawaii Medicaid Specialty Maps 2011

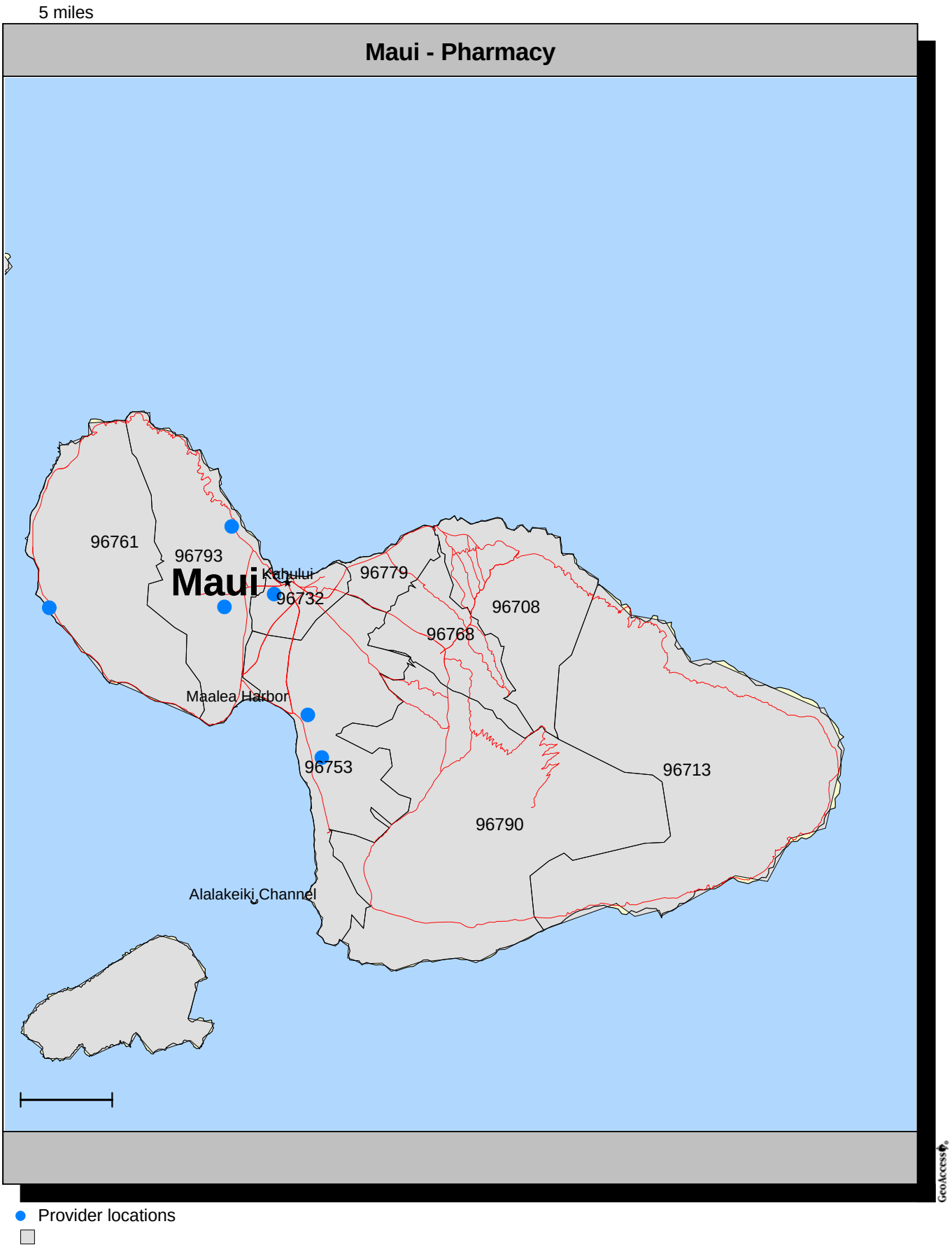
Behavioral Health Provider Locations

5 miles

- Single provider locations
- Multiple provider locations

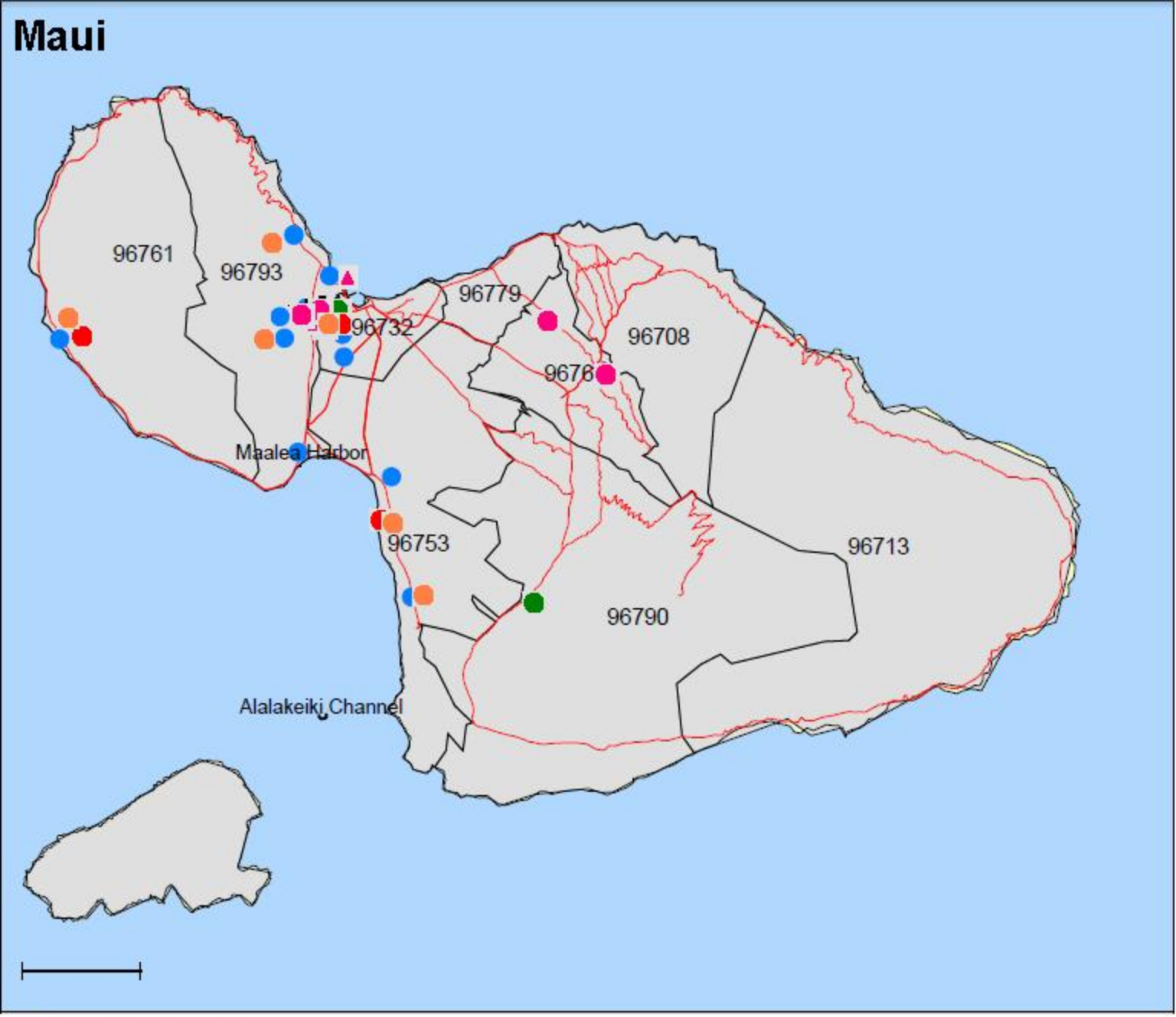
Primary Care Provider Locations

Pharmacy Locations



Specialist Provider Locations

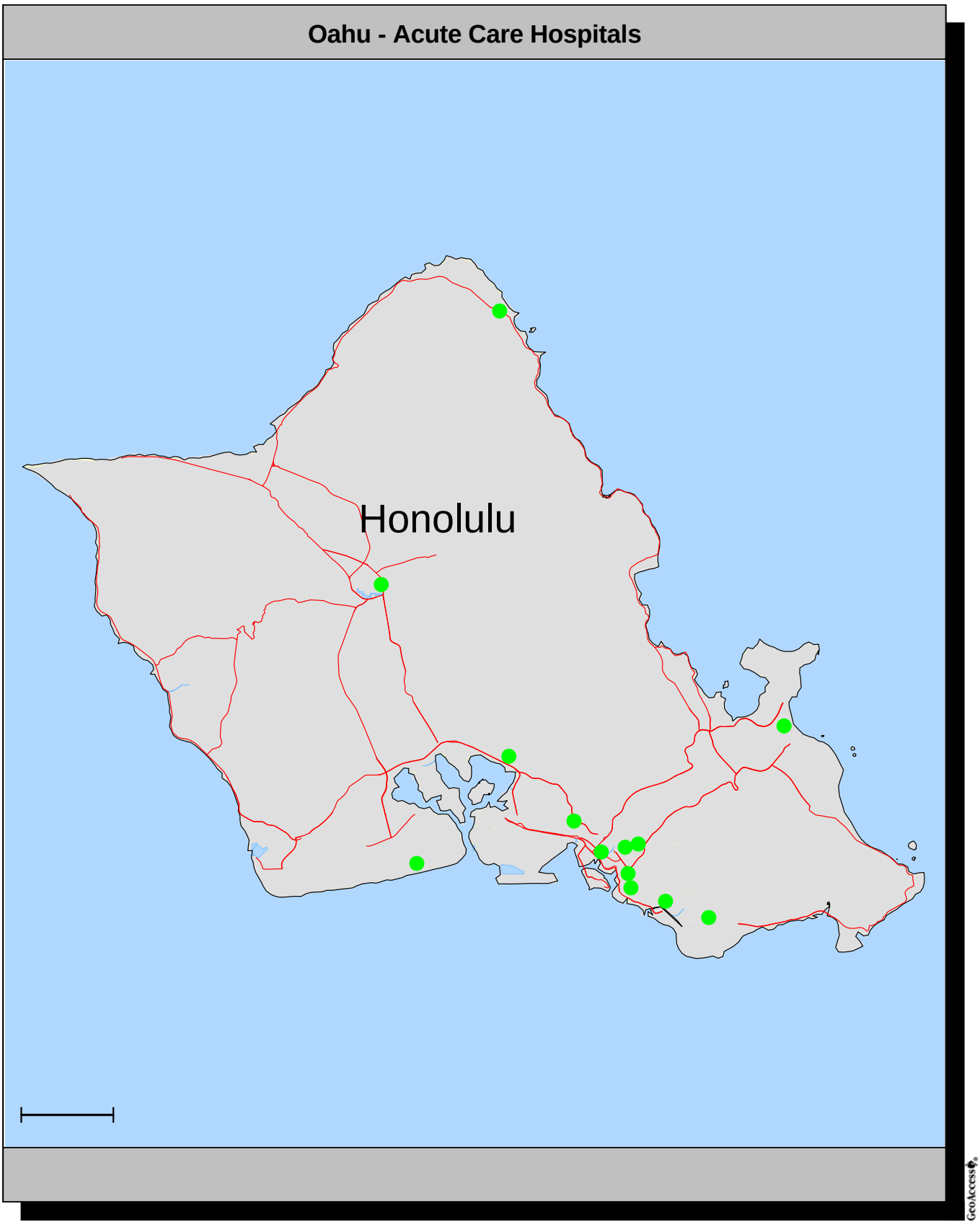
Provider locations



- Acute Care Hospitals
- Primary Care Providers
- Pharmacy
- Behavioral Health - Single Provider Locations
- Behavioral Health - Multiple Provider Locations
- Specialists

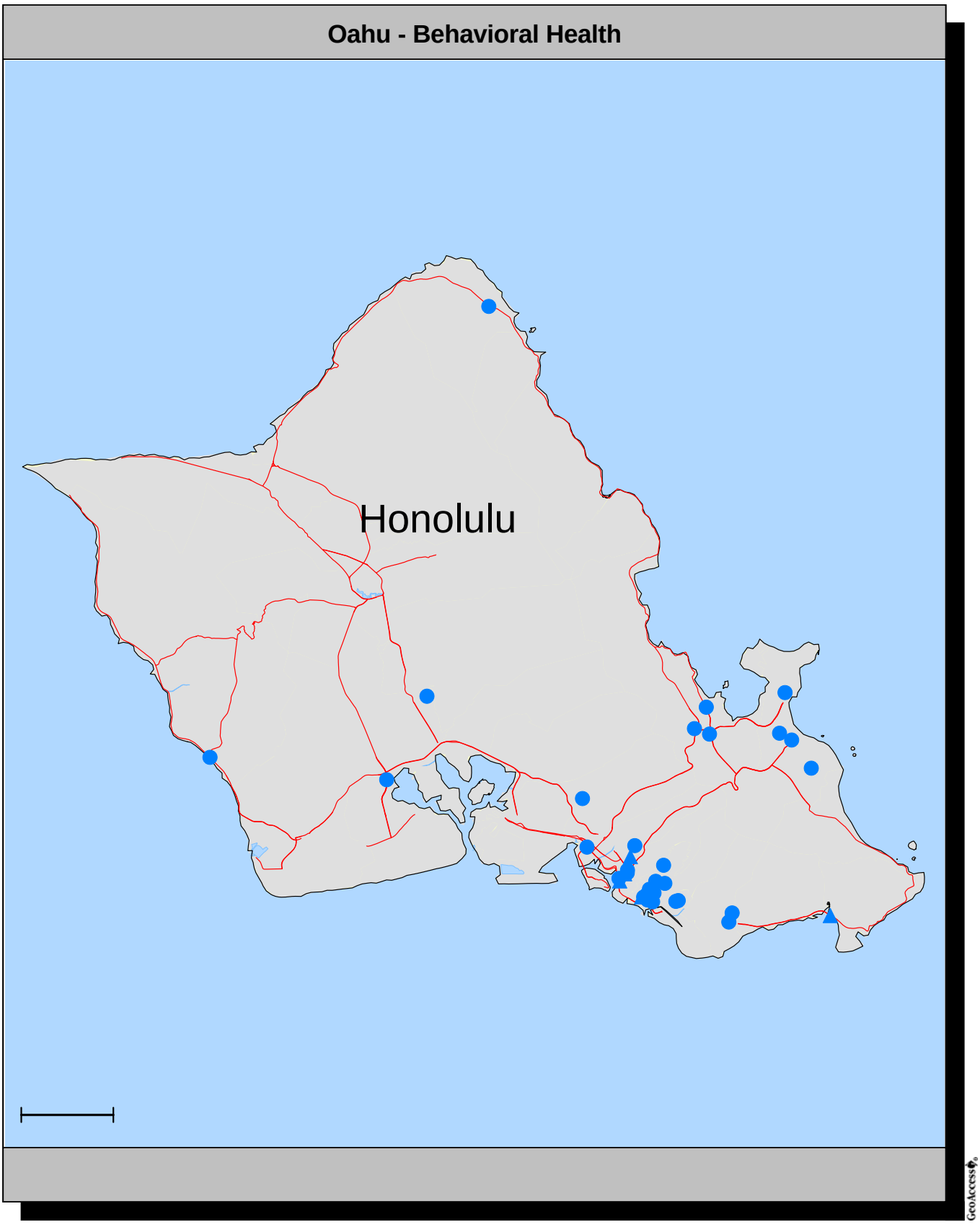
Acute Care Hospital Locations

4 miles



Behavioral Health Provider Locations

4 miles



Single provider locations
Multiple provider locations

Primary Care Provider Locations

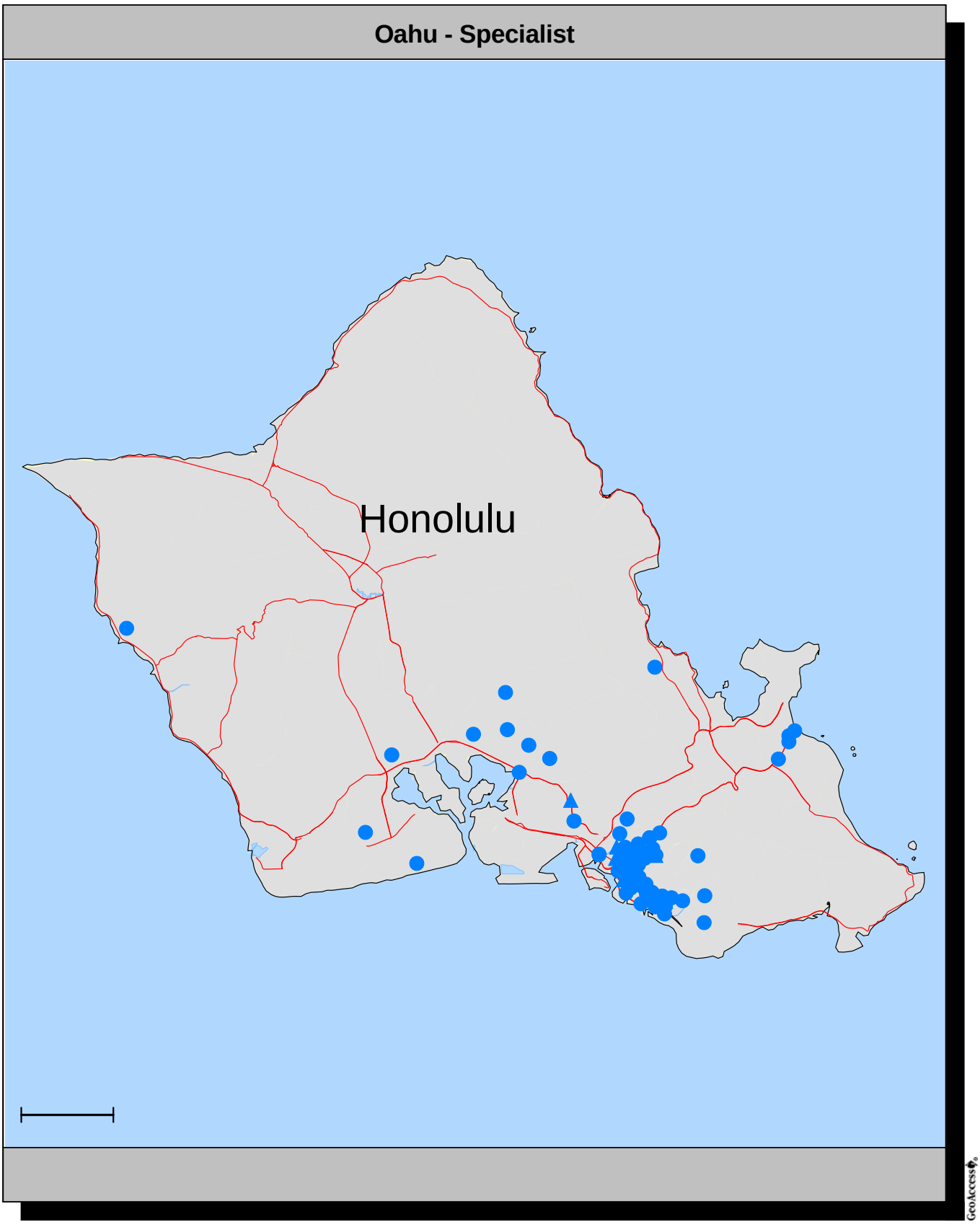
4 miles

Pharmacy Locations

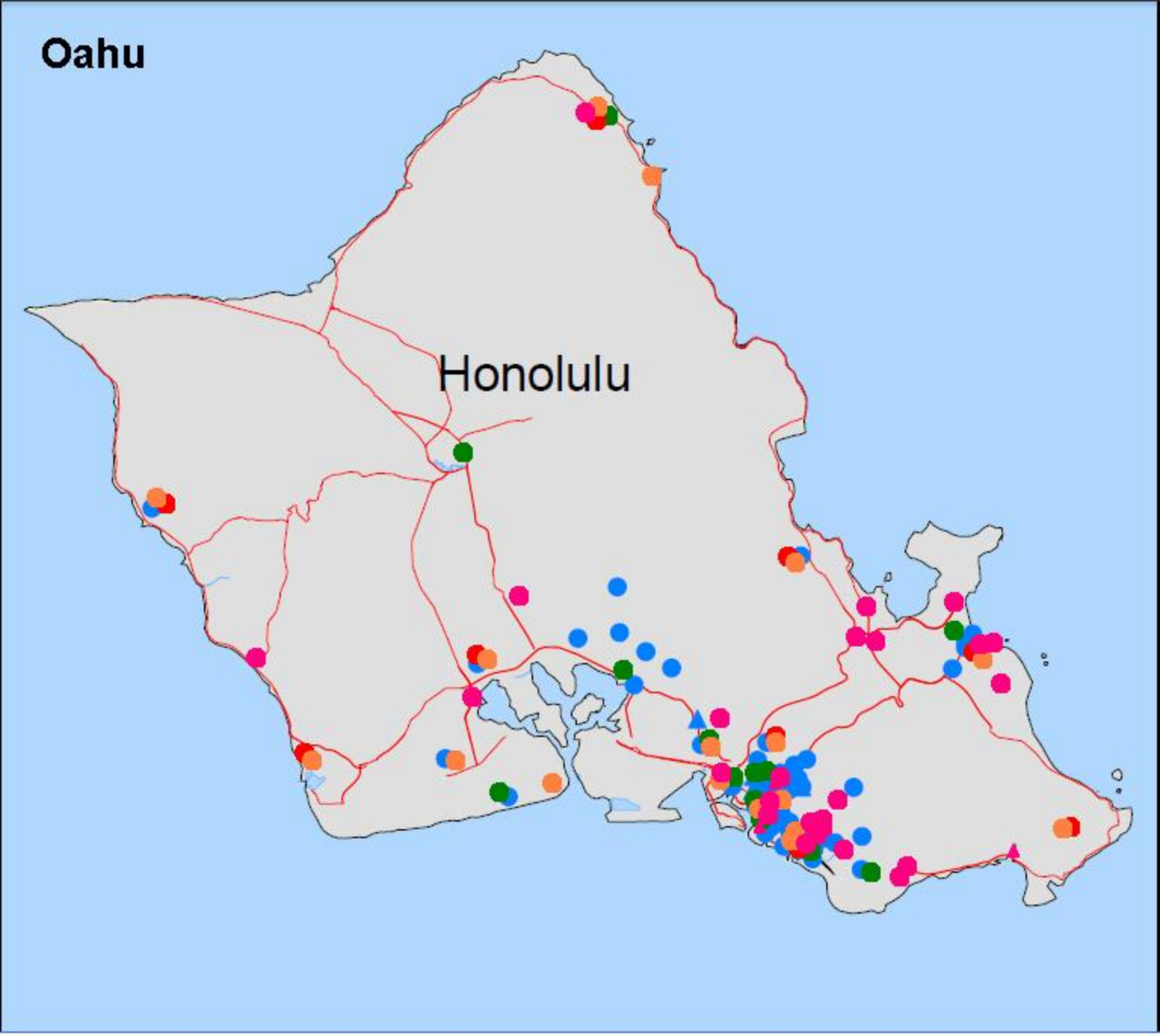
4 miles

Specialist Provider Locations

4 miles



Single provider locations
Multiple provider locations



- Acute Care Hospitals
- Primary Care Providers
- Pharmacy
- Behavioral Health - Single Provider Locations
- Behavioral Health - Multiple Provider Locations
- Specialists - Single Provider Locations
- Specialists - Multiple Provider Locations

KAISER PERMANENTE®

Section 80.320

Covered Benefits and Services

(30 pages maximum)

80.320.1 Covered Benefits and Services Narrative

The applicant shall describe:

A. Its experience providing, on a capitated basis, the primary, acute care, and behavioral health covered benefits and services as described in Section 40.700. This description shall indicate:

1. The extent to which this experience is for a population comparable to that in the programs;

Kaiser Permanente has provided covered benefits and services, on a capitated basis, to Hawaii QUEST members on Oahu since 1994 and on Maui since 1996. Subsequently, DHS added programs with limited benefits (QUEST-Net, QUEST-ACE and Basic Health Hawaii) of which Kaiser Permanente has been able to successfully incorporate into our care system. All of the services described in Section 40.700 are currently being provided by the Hawaii Permanente Medical Group, Inc. (HPMG) or, when not available, through contracted providers.

2. Which covered benefits and services the applicant does not have experience providing and how they intend to obtain the experience to provide these services; and

Kaiser Permanente has experience in directly providing for the vast majority of the required services. Kaiser Permanente maintains contracts with outside providers for the few services it does not provide itself. On rare occasion, we may also need the services of a non-Kaiser Permanente, non-contracted provider or facility. When this happens,

every attempt will be made to credential and contract with a provider on the island where the member lives, or if necessary, off-island. If the member requires services off-island, transportation, meals and lodging are provided for the member, and when medically necessary, an attendant.

3. The proposal for providing the covered benefits and services required in this RFP, including whether or not the applicant intends to use a subcontractor and, if so, how the subcontractor will be monitored.

Kaiser Foundation Health Plan, Inc. Hawaii region (Health Plan) contracts with Kaiser Foundation Hospitals (KFH) for inpatient services and the Hawaii Permanente Medical Group (HPMG) for professional services. Since 1971 and the first contract with the Hawaii Department of Human Services for the X5 program, the Health Plan has continued to provide covered benefits and services based on contract requirements. Today, KFH and HPMG providers have access to member-specific benefit information in Kaiser Permanente's electronic health record system, Kaiser Permanente HealthConnect (KPHC). KPHC will be updated to reflect the covered benefits and services in this RFP. Appropriate staff throughout the organization (Business Office, Referrals and Authorizations, UM, Social Work, etc.) have access to KPHC to ensure covered benefits and services are provided. Education on QUEST benefits and services will also be included in the new physician orientation program. All staff, KFH, and HPMG providers continue to have access to the QUEST case management staff located in Kaiser Permanente clinics, as well as the QUEST Medical Director. They are available to respond to benefit and service questions via telephone, in person, and at clinic meetings.

HPMG's vast provider network is able to provide almost all benefits and services required in this RFP. However, when necessary, we refer members to non-Kaiser Permanente providers. The Authorization and Referrals Management (ARM) Department screens each request for eligibility and benefit coverage before making the authorization.

B. Whether the applicant intends to provide additional services not required but allowed for in Section 40.700 and how it intends to provide these services;

Kaiser Permanente does not presently intend to provide additional services not required but allowed for in Section 40.700.

C. Its experience in providing services to members with special health care needs, including how it has identified such individuals and how it has provided needed services. In addition, the applicant shall describe how it intends to provide these services to its members in Hawaii; and

Kaiser Permanente has been providing services to low-income members with a wide variety of special needs since 1971. QUEST RN case managers review utilization reports and other data to help identify potential members with special health care needs.

In 2003, a Special Health Care Needs (SHCN) survey process was implemented to comply with the State of Hawaii Quality Strategy.

Identification of adults with SHCN is currently based on the following criteria:

- Adults whose use of prescription medication includes atypical antipsychotics and the chronic use of opioids, the chronic use of polypharmacy, and other chronic usage of specific drugs that exceed the use by other adults in the health plan as identified by the health plan; and
- Adults whose utilization of emergency room services is beyond that generally used by other adults in the health plan for the treatment of chronic medical conditions such as asthma and diabetes; and
- Adults who use or need speech therapy, occupational therapy, and/or physical therapy for chronic medical conditions that exceed the utilization by other adults in the health plan.

Identification of children with SHCN is currently based on the following criteria:

- Children who take medication for any behavioral/medical condition that has lasted or is expected to last at least twelve (12) months (excludes vitamins and fluoride);
- Children who are limited in their ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months;
- Children who need or receive speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last as least twelve (12) months; andChildren who need or receive treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months.

If any of the above criteria are met, a QUEST RN will conduct a Needs Assessment and, as appropriate, an Initial Assessment and an Individual Care Plan. The Individual Care Plan is monitored, assessed, and if needed, modified, until goals are met.

Kaiser Permanente will use the criteria set forth in RFP-MQD-2011-003 to identify members with SHCNs. We will continue to assess all members within 30 days of being identified as having special health care needs. All assessments will be performed by appropriately licensed and trained health care professionals. Services to members with SHCNs will continue to be provided as described in Section 80.320.5 of this Proposal.

D. Its competency serving the cultures in Hawaii and understanding the population served by the State's Medical Assistance program.

The Kaiser Permanente Hawaii Region's Cultural Competency Strategic Plan includes all required elements as described in Section 40.801 of the RFP. The Plan is reviewed annually with oversight provided by the Hawaii Diversity Council. The Council provides oversight to ensure that all members receive care that is culturally sensitive and provided within the context of the individual or cultural group. The Plan aligns diversity accomplishments and goals with the 14 National CLAS (Culturally and Linguistically Appropriate Services) Standards developed by the Office of Minority Health. The CLAS Standards help the Council to assess current programs, identify programs and data needs

and set priorities for the Region's Diversity Program. The Council provides guidance to managers in program planning, evaluation, and compliance issues.

Kaiser Permanente provides a strong language access program, including interpretation and translation services from nationally and locally contracted professional vendors. Interpreter services are available in-person, telephone, and video in 17 primary languages and 90 secondary languages. American Sign Language, lip reading, captioners, and note takers are available. Alternate formats such as Braille, audio and large print are also available upon request. Analysis on Limited English Proficiency members and their language needs are conducted annually to improve and enhance interpreter services.

Kaiser Permanente has a systematic process to collect member demographics data (race, ethnicity, gender, preferred language, interpreter need) in our electronic medical record system. Kaiser Permanente assesses the linguistic and cultural needs and preferences of our members. The Cultural Competency Strategic Plan includes a matrix depicting the race and ethnicity as reported by members in responding to the CAHPS surveys, Hawaii Health Survey data, Hawaii U.S. Census data, and HPMG physician and non-physician staff race/ethnicity data. The Plan describes conclusions drawn from the comparisons. Physicians and staff represent a broad range of ethnic/cultural backgrounds, which mirror the members' demographics and multi-lingual capabilities.

Kaiser Permanente has a cross-continuum approach to providing cultural competency training to physicians and staff. Mandatory diversity training is integrated into physician and staff's new hire orientation, as well as clinical competency classes. Cultural competency is integrated into training about specific clinical issues such as diabetes and asthma. We have an online library of resources and tools such as provider handbooks, culturally competent care toolkits, interpreter services guidelines, fact sheets, and videos.

The Interpreter Services Program tracks and monitors all patient concerns relating to cultural and linguistic services. In addition, annual analysis on all member concerns relating to

language, ethnicity, or culturally competent care is conducted and trended. Each concern is investigated and resolved to the satisfaction of the member.

Our Cultural Competency Strategic Plan is made available to all in-network practitioners at no charge via the online HPMG practitioner manual and the Clinical Content Library for internal practitioners. Affiliated (external) practitioners have access to the Cultural Competency Strategic Plan via the Affiliated online practitioner manual. Annual email communication is made to internal practitioners and staff on how to access the Cultural Competency Strategic Plan. Annual communication is made in the Affiliated Quality Summary to Affiliated practitioners on how to access the Cultural Competency Strategic Plan.

80.320.2 Behavioral Health Narrative

The applicant shall describe its planned approach to providing behavioral health and substance abuse services as required in Section 40.740.2. Specifically describe how the following requirement will be implemented:

A. Assessment of behavioral health needs;

Behavioral Health Services (BHS) is a self referral department; members may call directly to set up an appointment without a referral from any provider. Members may call the BHS Department to set up an appointment with a psychiatrist or therapist as appropriate. New QUEST members are given a questionnaire asking about their current health status and medication needs. If the member is in need of behavioral health services, a BHS Call Center Therapist will contact the patient. An initial screening will be completed by call center therapists to determine acuity of need and triage as appropriate. Once screening is complete, the therapist will schedule a full diagnostic evaluation with a psychiatrist or therapist. Providers will complete a Diagnostic Evaluation to determine diagnosis and treatment plan. Treatment plans may include a referral to additional Severe and Persistent Mental Illness services if the member meets criteria. Ongoing assessments occur as clinically indicated throughout the course of treatment.

B. Assurance of case management within acuity levels;

Pursuant to Section 40.740.2.c.i, case management intensity and frequency will be determined and adhere to the standards set forth in the tables provided. Monthly data is collected by the Utilization Management (UM) Coordinator to monitor frequency of contact as well as attempts made. Global Assessment Functioning (GAF) scores are determined by the BHS provider(s) providing treatment to the patient. Case managers will be responsible for adhering to the standards set forth, with clinical supervision provided on site within the case management agency. If a patient is unable to be located, the case manager will provide outreach attempts in at least two modalities in an effort to engage with the patient. Patients have the right to refuse treatment.

C. Assurance of medication refills for psychotropic medications;

New QUEST members are assisted by the New Member Pharmacist who works directly with members to identify their current medication prescriptions and assist with refills during the transition.

Current QUEST members are able to request refills in person, online, and via telephone. The Behavioral Heath UM Coordinator works closely with our affiliated care providers who provide case management services to our SPMI population. Every effort is made to be proactive in the course of treatment and recovery. Release of Information forms are signed to allow an exchange of information including but not limited to new medications, changes of medications and need for refills of medication. Members are encouraged to work with their case managers to share all aspects of their ongoing treatment including current medication types and dosages. Case managers meet with members regularly to discuss ongoing recovery topics including medication. Medication discussions involve patient knowledge of current medication prescriptions, complaints of side effects, efficacy, and questions. The case manager works with the member to help them provide feedback and ask questions of their psychiatrist as appropriate.

On a monthly basis, the UM Coordinator provides a list to the Pharmacy Department of patients currently receiving additional behavioral health services. Pharmacy runs a report to determine last refill and next refill due dates. Release of information between Kaiser Permanente and the case management agencies allows information to be shared. Case managers work with patients to identify the need for refills, assist with requesting refills, and assistance in determining how to obtain medications in person or via mail. The UM Coordinator and the case managers are able to work with the member and the Kaiser network throughout the month to address any medication refill needs.

D. Prevention of unnecessary emergency room utilization and acute psychiatric hospitalizations; and

Kaiser Permanente focuses on keeping our members as healthy and encouraging them to thrive. We provide treatment, support and resources to ensure patients are empowered to take care of their health and encourage them to work with their health care team to proactively catch problems before they require intensive interventions including, but not limited to, visits to the Emergency Room. We have preventative programs including groups, individual therapy with treatment plans and discharge criteria, case management services, PIOP, IOP, and Chemical Dependency programs. In the area of behavioral health, members who meet the criteria for additional services and who wish to participate are authorized for case management. Case managers work with members to identify individual goals, interventions, responsible parties, and measurable outcomes. These goals and interventions are written into a recovery plan that is reviewed regularly and updated every six months or sooner as goals are achieved and/or changed. Members also create crisis plans in an effort to identify and plan for possible crises. The crisis plan will include examples of crises and options of who to contact when a crisis occurs. Options may include but are not limited to family, friends, sober supports, ACCESS and case manager. Patients may utilize the ACCESS line for crisis services such as Crisis Mobile Outreach and Licensed Crisis Residential Shelters in the event of a crisis. They may also call their case manager or case management agency. This planning is sometimes enough to avert a crisis because a plan is already in place. If a crisis does occur, a patient is able and encouraged to utilize the plan to reach out to a variety of resources, hopefully decreasing the need for a visit to the emergency room or hospitalization.

Our emphasis is on prevention. However, if the patient is seen in the Emergency Room at Kaiser, psychiatric consultants are available 24/7 to assess and triage for appropriate care. Safety for the patient is our primary goal. If the patient is seen in the Kaiser Permanente emergency room, a psychiatric consult may be ordered by the treating physician. Patients seen by behavioral health staff for consultation have the opportunity to speak with clinicians who can provide crisis interventions. In such cases where hospitalization is not warranted, the behavioral health clinician will work with the patient to schedule follow up with the behavioral health department in the near future.

If the patient is seen in a non-Kaiser Permanente emergency room, the hospital will complete an assessment to determine if patient meets criteria for inpatient psychiatric hospitalization. During business hours, a patient who does not need to be admitted may work with the hospital staff to contact the Kaiser BHS call center to schedule a follow up appointment with the department. After business hours, a patient may contact the advice nurse and the information will be communicated to the call center. The call center will contact the patient when any information regarding an ER visit for behavioral health reasons is received to offer further outpatient care. Admission for acute psychiatric hospitalization will be determined by medical necessity.

E. Follow-up after acute psychiatric hospitalizations.

Kaiser Permanente's BHS department works directly with the staff at the various acute psychiatric units to set up follow up appointments after an acute psychiatric admission. Patients are scheduled to be seen within seven days of discharge. The Primary Care Provider of the patient is notified of hospitalization and discharge as indicated.

See Flowchart

80.320.3 Prescription Drug Narrative

The applicant shall detail how it intends to maximize generic prescribing, minimize use of brand-name prescriptions, manage prescription drug costs, and implement Section 346-59.9, HRS, Psychotropic medication law.

Kaiser Permanente Hawaii uses defined pharmacy management policies and procedures to ensure the safe, appropriate and evidence-based use of medications, including use of generic drugs and formulary compliance. All pharmacy management policies & procedures, as well as formulary decisions, are approved by the physician-led Pharmacy & Therapeutics Committee. The Committee consists of 17 members, of which 12 are MDs. As an example, on a quarterly basis, our physicians and pharmacists review non-formulary drug utilization reports to ensure appropriateness of non-formulary drugs & ensure consistent standardized and evidenced-based professional practices. This work has resulted in the following in 2010: 88% generic drug use and 95% formulary compliance for our commercial and QUEST members, and 86% generic drug use and 99% formulary compliance for our Medicare Part D members. We expect similar rates of generic use and formulary compliance in 2011 and 2012.

We have a multidisciplinary team, co-led by the HPMG Chief of Evidence-Based Pharmacy & Therapeutics and the Chief of Pharmaceutical Services, titled DUAT (Drug Use Action Team), who meet monthly to review overall drug utilization, formulary compliance and focused drug initiatives, evaluating several standard reports, including pharmacy location brand-generic dashboards, and focused initiatives scoreboards. This information is shared with the HPMG Executive Board, all HPMG Professional & Practice Chiefs, & then cascaded to staff physicians as deemed appropriate by the Chief. Clinical pharmacists & formulary management staff may assist the Chief upon request, to support practices that are evidence-based, encouraging minimal practice variation. In 2011, this team reduced drug costs to members in upwards of $500K through June 2011.

With regards to implementation of Section 346-59.9 HRS Psychotropic medication law, Kaiser Permanente Hawaii has complied with this Act by ensuring the access and availability of all

psychotropic medications to Kaiser QUEST members. Kaiser Permanente Hawaii maintains a formulary of antipsychotic, antidepressant, and anti-anxiety medications for Kaiser Commercial and QUEST members, and uses our formulary exception process when use of a formulary medication(s) has failed for that member, as defined in our pharmacy management policies & procedures.

80.320.4 Early and Periodic Screening Diagnosis and Treatment (EPSDT) Narrative

The applicant shall describe:

A. Its interactions with community partners including, but not limited to, The American Academy of Pediatrics -Hawaii Chapter or Hilopa'a Family to Family Health Information Center, to promote ESPDT awareness;

Almost all EPSDT services are provided by Kaiser Permanente providers so the focus of our EPSDT awareness activities is performed within the organization. However, we continue to promote EPSDT awareness throughout the state by partnering with Hilopa'a through the state's EPSDT committee. We also have an HPMG physician who represents Kaiser Permanente and serves as Vice President of the Hawaii Chapter of the American Academy of Pediatrics.

Kaiser Permanente's EPSDT Coordinator provides ongoing EPSDT education in the clinics to physicians, APRNs, nurse practitioners, clinic nursing staff, outreach nurses, and Case Manager Associates. The training content includes the importance of compliance with EPSDT requirements, review of the periodicity schedule, documentation, process for referrals for additional services, use of community agencies, changes in requirements, results of automated reporting and medical record audits, and the role of the Case Manager Associates and outreach nurses in providing assistance to children. The EPSDT Coordinator answers questions and offer suggestions to the staff to improve EPSDT service and acts as a resource to ensure that children are receiving needed services (e.g., hearing aids, supplies, etc.). The EPSDT Coordinator reviews medical chart documentation audits

of EPSDT periodicity elements and inform/discuss results with the physicians. The quarterly audits are conducted on frequently missed elements in the periodicity schedule. The results of these internal audits are released to the practitioners. Practitioners who miss periodicity elements are notified of the missed element and are re-educated on the use of the correct "smartsets" to be inclusive of all the EPSDT elements. The physician in charge of a clinic is also notified if a clinic practitioner continues to miss EPSDT elements.

B. The procedures it will follow to address the following situations:

1. A parent who is not adhering to periodicity schedules; and

The provider and clinic staff make every attempt to have the parent reschedule an appointment for a missed EPSDT exam or a missed referral for diagnostic services. If the clinic staff is unable to contact the parent to reschedule the appointment, a referral is made to a QUEST case manager (Outreach Nurses or Case Manager Associates). At each subsequent encounter, the case manager will inform the parent/guardian of the importance of EPSDT services and their responsibility in keeping appointments, returning for reading of tuberculin skin tests, re-check of illness, appointments, etc. The outreach team follows up on referral appointments for problems identified through EPSDT screens and diagnostic treatment services. If, after two phone attempts, they are unable to reach the family, the Case Manager Associate will send a letter reminding the patient or patient's parent/guardian to reschedule. The child's name is then returned to the appointment tracking system and the process will be repeated at the next well-child visit.

2. A parent who is not following up with the children's referrals for diagnostic treatment services; and

If the family is not following up on medical problems identified during an exam, a QUEST RN will be contacted. The RN will conduct a Needs Assessment and will contact the parent by phone or home visit, depending on the urgency of the medical need. If there is medical neglect involved, the Care Coordinator/Case Manager may, of if applicable,

shall request the assistance of law enforcement and/or report the same to Child Protective Services.

Kaiser Permanente will continue to review medical records to determine parent/guardian compliance in obtaining EPSDT services and provider compliance in including appropriate documentation when EPSDT services are provided, and to ensure that needed health care services are received.

C. The applicant shall provide specific data from its largest Medicaid contract with documentation to verify the statistics on the:

1. **Percentage of children who receive all screenings pursuant to the pediatric periodicity schedule;**

   80% (per 2010 CMS 416 report)

2. **Percentage of children identified for referral to follow-up services; and**

   9% (per 2010 CMS 416 report)

3. **Percentage of children so identified who actually receive follow-up services.**

   Of the 9% of children who are referred to follow-up services, most of the services are provided within Kaiser Permanente's vast provider network (e.g. dietician, weight management, behavioral health, etc.). Kaiser Permanente maintains all documentation in the automated medical record of referrals for follow-up services (within our network and also to affiliates) and of those who actually receive follow-up services. Although the referral information is documented in the charts we are not currently able to extract the data to provide the requested information. For services not provided within our contract, such as dental care, practitioners make recommendations but no formal referral is made or documented since routine dental care is not included in the QUEST contract.

80.320.5 Care Coordination/Case Management (CC/CM) System/Services Narrative

The applicant shall provide a comprehensive description of its CC/CM system/services (either in Hawaii, another state, or its proposed CC/CM system/services for Hawaii), including policies and procedures as well as mechanisms developed for providing CC/CM system/services. The applicant shall describe how it shall meet the requirements in RFP Section 40.752 -Care Coordination/Case Management System, and RFP Section 40.751 -Services for Members with Special Health Care Needs (SHCNs).

At a minimum, the applicant shall describe and address:

A. The organizational structure of its CC/CM system and services including the staff to member caseload ratios;

Care Coordination/Case Management (CC/CM) is provided to QUEST members by QUEST-specific case management staff. The staff includes two full-time and one call-in RN Case Managers, and three Case Manager Associates (paraprofessionals) on Oahu. On Maui, we have one RN and one LPN Case Manager, and one Case Manager Associate. An RN supervisor oversees the staff and all QUEST case management activities. Case management staff is located in clinics on Oahu and Maui. CC/CM is also provided by region-wide disease specific and/or population specific RN Case Managers, Panel Support Teams (a multidisciplinary group composed of APRNs, dieticians, and clinical pharmacists), and hospital and clinic-based Social Workers and Discharge Planners. Case Managers are also supported by a variety of clinical teams (such as the Coumadin clinic, breast team, colorectal screening team, etc.)

The kind of CC/CM a member receives is dependent on his/her health status and psycho/social and environmental issues that may be impacting health care. All case managers are part of the Health Care Team, led by the member's Personal Care Physician.

Caseloads are divided among the staff based on the member's home address and the clinic where the member's PCP is located. The number and intensity of cases are regularly

evaluated. If there are a disproportionate number of cases or cases of higher acuity, the caseloads will be adjusted and re-distributed among other staff members. The constant referrals, case finding, and closure of cases keep the caseloads manageable. Each RN Case Manager has approximately thirty open cases t any given time

B. How the CC/CM system ensures that members, family/designated representatives, providers and health plan staff are informed about the availability of CC/CM services, how to make a referral for services, and how to access services during and after regular working hours;

The Case Manager Associates' and RN's daily presence in the clinic setting serves as a constant reminder to members, family, providers and staff of the availability of CC/CM services. Practitioners are educated about the availability of CC/CM services during new provider orientations and during periodic clinic in-services. They also learn of CC/CM services on an individual basis directly from the case management staff in the clinic, via regional broadcasts, newsletters, flyers or posters placed in the clinics.

Each new member is sent a member handbook which details the availability of CC/CM services. A new member Welcome Letter includes the direct phone numbers of each Case Manager Associate along with the clinic they cover as well as the phone number to the Kaiser Permanente QUEST call center.

Referrals to a case manager are made by telephone, email, in person, or by request via the electronic medical record. All QUEST case managers are available during regular working. A staff person is also available after hours to ensure accessibility to members' and providers' urgent case management needs.

See attached Policy #6547-02-07 Education of Benefit Coverage and Case Management Services.

C. The needs assessment process including the criteria used to screen/identify members in need of CC/CM services;

A Needs Assessment will be conducted for members referred for CC/CM and identified as having multiple and/or complex problems. Referrals for CC/CM may originate from any one of these sources: Primary Care Physician, Medical Staff, the member, the member's family/caregiver, Case Manager Associate, or as a result of a completed Special Health Care Needs Survey. Members meeting the any of the high risk criteria will receive case management services.

See attached "High Risk Criteria Protocol"

D. If the applicant elects to develop differing levels of CC/CM services, a description of the levels of services, the criteria to be used in determining what level of service a member will receive and how cases are prioritized;

The following criteria will be used to determine the level of service a member will receive:

Acuity 1: (Light touch)

Needs assessment only (case opened and closed on the same encounter)

A. Single contact, non urgent issue

Examples:

- Maintenance care
- DME/supplies
- Bus/taxi transports request
- Eligibility question
- Benefit question
- Chart Review/Phone contact of a SHCN member

Acuity 2: (Medium touch)

Needs Assessment, Initial Assessment, and Care Plan

A. Two to four contacts with member, and/or

B. Case estimated to be opened longer than 1 month, and/or

C. Two or more interventions needed

Examples:

- Chronic medical condition, stable
- Transport from Maui to Oahu
- SHCN survey member needing follow-up

Acuity 3: (Heavy touch)

Needs assessment, Initial assessment, Care Plan/s

A. More than four contacts with member, and/or

B. Case estimated to be opened longer than 3 months, and/or

C. Multiple interventions needed, and/or

D. Multidisciplinary team involved in care coordination

Examples:

- Lead case
- CPS case
- Chronic medical conditions, unstable
- Prenatal High risk
- Developmental delays
- Behavioral health diagnosis
- Pain management
- Disability candidate/ADRC
- Member needing transition of care to or from another health plan
- Mainland transport
- Catastrophic cases

Cases will be prioritized based on the acuity system and the urgency of the problems identified.

E. How the CC/CM system addresses coordination and follow-up of outpatient and inpatient care/service needs as well as referrals to, and coordination with, community-based resources/services that provide services that are not covered by the programs;

Kaiser Foundation Health Plan, Inc. (Health Plan) provides most services through its own hospital and clinics; through physicians of the Hawaii Permanente Medical Group, Inc. (HPMG); and, to a much lesser extent, through non-HPMG contracted providers. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST. This agreement promotes the integration, coordination and follow-up of outpatient and inpatient care/services. Services not provided within Kaiser Permanente are referred to contracted providers and/or community resources.

The assigned CC/CM coordinates the service delivery that is needed by the member. The electronic medical record is regularly reviewed to ensure services are provided, follow-up is done, and also to prevent duplication of work. Referrals to community-based resources/services not covered by QUEST are coordinated and evaluated by the assigned CC/CM and documented in the electronic medical record.

See attached Policy #6547-02-14 Individual Care Plan

F. The processes for monitoring emergency room utilization and informing members of options for urgent care, after-hours care, and twenty-four hour nurse line;

A monthly utilization report that lists all patients who've utilized the emergency room is generated. The RN Case Managers review the electronic medical record for appropriateness of utilization and will contact those members needing further assistance with access to care, those needing follow-up outpatient visits, and/or general education on appropriate emergency room utilization and other care options. Providers also have access to emergency room utilization information through the Panel Support Tool available by hyperlink in the electronic health record (EHR).

All new QUEST members are informed of the options to accessing care such as urgent care, after hours care, and the Nurse Advice Line in the member handbook. Additionally, all new adult members on Oahu are contacted by a Case Manager Associate (CMA) for "new

member onboarding". The goal of the onboarding process is to help new members navigate and access care and services at Kaiser Permanente. The CMA confirms receipt of the new member handbook and provides information on the hours of operation and phone numbers to after hour care, urgent care, and the 24-hour Advice Nurse Line, as well as the kp.org website. On Maui, a pilot program for new QUEST members was recently implemented which is similar to the Oahu onboarding process. New members are contacted soon after enrollment into the health plan and information on options to accessing care is provided. This information is reinforced during a follow-up face-to-face meeting with a QUEST RN case manager

G. The processes for receiving and sharing pertinent information, and interfacing with the member, the member's PCP and other relevant providers, and as appropriate, the member's family, and applicant departments, to promote continuity of care and coordination of services. In addition, discuss how the member and/or the member's family are involved in the process for decisions regarding care;

The Primary Care Physician (PCP) is the primary coordinator of care and services for the patient. Documentation of all case management activities, including any consultations, interactions, case conferences, referrals, revisions, correspondence and other activities related to the case management services, is made in the member's EHR. Each member of the health care team involved with the case is copied on notes made in the EHR. The member is informed about the plan of care and their involvement in it is highly encouraged. Family members/caregivers are included, if agreed to by the member, and interactions with them are also documented in the EHR. Communication to all parties is made through e-mail, in person and/or by phone. Follow-up and monitoring is done by the responsible parties assigned to the case. Education and interaction with the member/family or caregiver is made as needed. Case conferences are held whenever necessary. Feedback is provided to the PCP/practitioners. The CC/CM also helps to facilitate and encourage the member's participation in their own care and to express any concerns about the care provided.

See attached Policy #6547-02-04 Communication/Documentation of Pertinent Member Information.

H. The mechanisms to ensure that the implementation of the member's treatment plan is monitored/evaluated for effectiveness, and is revised as frequently as the member's condition warrants;

The member's treatment plan is monitored and evaluated for effectiveness. Evaluation is ongoing until case closure. The CC/CM's documentation, in collaboration with the PCP as needed, will reflect interventional effectiveness and/or revisions related to the member's condition. The electronic health record has an alert system in place to remind the RN Case Manager when the treatment plan is due for review. At least every six months, a competency performance peer review is conducted on the QUEST CC/CM staff. The Case Management Supervisor reviews the peer review findings with the each staff person and provided counseling and training, if needed.

See attached Policy #6547-02-14 Individual Care Plan

I. The requirements for documentation of all CC/CM activities;

Documentation of all CC/CM activities is made at every level of the case management process. There are four stages of documentation. They are Assessment, Planning, Implementation and Evaluation. The RN performs a Needs Assessment. The Needs Assessment and the member's medical risk will determine whether to initiate case management. When a case is initiated, an Initial Assessment is completed by the RN with the member and/or the member's family or caregiver. An Individual Care Plan (ICP) is developed based upon the medical treatment plan (as recommended by the PCP or specialty MD) with the member's agreement and willingness to participate in the plan of care. Evaluation during the care planning process is ongoing until case closure. Documentation of the case management activities, including any consultations, interactions, case conferences, referrals, revisions, correspondence and other activities related to the case management services is made in the member's EHR.

See attached Policy #6547-02-12 Documentation of Case Management Activities

J. The criteria for discontinuing CC/CM services;

Case management services will be terminated upon successful completion of the member's care plan interventions. Below are examples of when the CC/CM may close the case, but are not limited to:

- Interventions have been successfully implemented
- Member is stable and able to function independently or appropriately with the support of the family member/caregiver or resources
- Member declines care coordination
- Member is no longer a Kaiser Permanente QUEST member
- Care Coordination is completed
- CPS worker acquires case
- Disease process is controlled and managed medically by a provider
- Member is compliant with medical regimen
- Barriers to care are resolved
- Member demonstrates understanding of health condition
- Member is linked to community-based services

See attached Policy #6547-02-11 Discontinuing Case Management Activities

K. How the CC/CM system is linked to the applicant's information system. This description shall include how the information system tracks CC/CM activities, support evaluation of the CC/CM system and generate reports;

All CC/CM activities are linked to the EHR. An electronic case reminder is generated when a case is due for review. Future appointments may be made through the EHR. If the patient does not show up for this visit, a no-show algorithm is triggered which assists the CC/CM staff in tracking compliance with EPSDT well child visits. The information system does not specifically support evaluation of the CC/CM system, nor does it generate any specific reports.

L. How the applicant will identify and manage its highest risk (top 1%) members; and

A utilization report will be generated to show the top 1% of the highest costing adult members, and another report for the top 1% of the highest costing child members. Both reports will be based on all services incurred per member for a certain period of time. The RN Case Managers will review the electronic health records of the highest risk members, conduct a Needs Assessment, an Initial Assessment, and then develop an Individual Care Plan, as appropriate.

An Individual Care Plan (ICP) is developed based upon the medical treatment plan (as recommended by the PCP or specialty MD) with the member's agreement and willingness to participate in the plan of care. Evaluation during the care planning process is ongoing until case closure. Documentation of the case management activities is made in the member's EHR which can be reviewed by the entire care team. Those members with chronic diseases will be placed in the appropriate chronic disease management programs.

In our current care coordination/case management (CC/CM) process, all members who meet the high risk criteria will have a Needs Assessment, an Initial Assessment and an Individual Care Plan with the same vigor as those we will identify as the top 1%. The breath of services provided is based on the individual member's needs. It includes, but is not limited to, coordination of care, assistance with discharge planning, referrals to community resources, transition of care, travel/meals/lodging arrangements and coordination, education, reinforcement of care plans, etc.

While we will produce a utilization report of the top 1%, we are likely already managing this population as referrals are routinely made to the QUEST case management staff. Our hospital, clinic and health plan staff are very much aware of what the QUEST case management staff do and the service they provide as they have firmly established themselves as a valuable resource for managing QUEST members.

M. How applicant CC/CM activities will be coordinated with and may be delegated to providers.

The primary care coordinator, who is the PCP, is recognized as the main point of contact for our members. The CC/CM works with the PCP through referrals, email, and phone calls to facilitate communication with the patient and coordinate care with the integrated health care team. Appointment and referral adherence tracking is done and reminder phone calls and letters are sent to the member. Documentation of all case management activities, including any consultations, interactions, case conferences, referrals, revisions, correspondence and other activities related to the case management services, is made in the member's EHR. Each member of the health care team involved with the case is copied on the notes made in the EHR.

80.320.6 Transition of Care Narrative

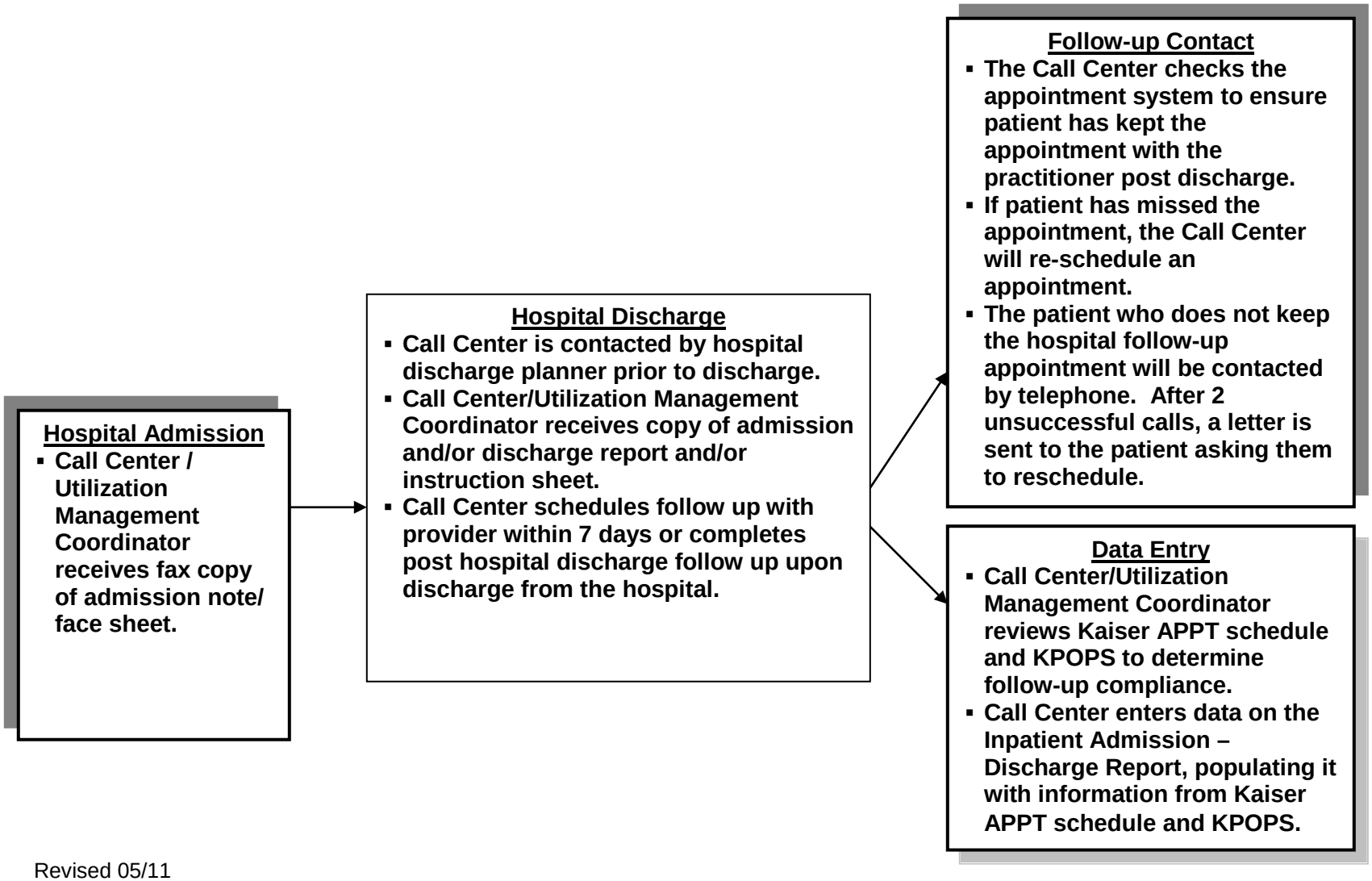
The applicant shall describe how it will ensure that members transitioning into its health plan receive appropriate care, including how it will honor prior authorizations from a different QUEST health plan or a QExA health plan. The applicant shall also describe how it will coordinate with a new health plan when one of its member's transitions out of its health plan and into a different QUEST health plan or a QExA health plan. As part of this narrative, please provide specific examples.

Kaiser Permanente QUEST staff will assist members transitioning into the health plan. The new member may be identified by the Special Health Care Need's survey, through a referral, or through contact with any staff member. Any provider may contact the case management staff for assistance with care coordination. A Nurse Case Manager (CM) or Case Manager Associate (CMA) may be assigned to assist with care coordination. The CM or CMA will assist the member with establishing a Primary Care Provider (PCP). The PCP's office, CM or CMA will obtain consent to retrieve medical records. The PCP will determine medical necessity of existing or needed medical equipment. The PCP will order medically indicated equipment by following our established prior authorization process. Prior authorizations from the previous plan will be honored for 45 days or until the member's medical needs have been assessed by the PCP of the new plan.

Kaiser Permanente will also cooperate with the member in transitioning out of our health plan. Kaiser Permanente will continue to provide access to care and quality health services to the member until such time as the care is transitioned to the member's new health plan. This includes behavioral health treatment. Kaiser Permanente shall cooperate and assist the new health plan with obtaining the member's medical records and other vital information. HIPAA requirements will be followed. Kaiser Permanente will remain responsible for the care and the cost of the services provided to the member for the remainder of the month or through discharge, if the member moves to a different service area or is hospitalized in the middle of the month. If the member is being discharged from an out-of-state or off-island facility, Kaiser Permanente is responsible for returning the individual to their island of residence and arranging for the transition of services even if the individual is disenrolled from the plan prior to discharge from the facility.

As needed, the Quest Medical Director may contact his/her counterpart at the new health plan to assist with coordination of care for problematic or complex cases.

BHS Follow-up Post Psychiatric Hospitalization



ENTITY/DIVISION

QUEST/GOVERNMENT PROGRAMS

Policy #: 6547-02-04
Original Date: 11/23/01
Revision Date: 03/22/10

SUBJECT & TITLE

COMMUNICATION/DOCUMENTATION OF PERTINENT MEMBER INFORMATION

COVERAGE

QUEST MEMBERS REQUIRING CASE MANAGEMENT SERVICES

RESPONSIBILITY

QUEST Case Management Staff

POLICY

In order to ensure continuity of care and coordination, pertinent member information will be shared with the member, appropriate family members/caregiver, Primary Care Physician and other relevant providers and HP departments.

PROCEDURE

1. Assessment results shall be used to determine the member's needs.

2. A Care Coordinator will be assigned to the case.

3. The Care Coordinator will communicate the member's identified needs to the member's Primary Care Physician (PCP) and other practitioners and staff involved with the member's care.

4. A treatment plan will be developed in consultation with the member, or appropriate family members or caregivers, representatives of various services involved in the member's care, and Primary Care Physician, as needed.

5. Pertinent information such as the member's condition/needs, the medications/treatments prescribed, the outcomes of referrals, identification of additional problems/barriers and the status of problem resolution shall be shared with the PCP, member, appropriate family members or caregivers and representatives of various services involved in the case.

6. Information will be conveyed to the appropriate people (stated above) to ensure proper coordination of services and treatment outcomes, as warranted.

7. Documentation of all Case Management activities, including any revisions, consultations, interactions, case conferences, referrals, correspondence and other activities related to the case management services will be made in the member's electronic medical record.

8. Communication with the Primary Care Physician will be through any of the following: electronic chart, messaging, electronic notes, email, telephone, personal contact, case conferences.

ENTITY/DIVISION

QUEST/GOVERNMENT PROGRAMS

Policy #: 6547-02-07
Original Date: 11/23/01
Revision Date: 03/22/10

SUBJECT & TITLE
EDUCATION OF BENEFIT COVERAGE AND CASE MANAGEMENT SERVICES

COVERAGE
QUEST MEMBERS

RESPONSIBILITY
QUEST Case Management Staff

POLICY
Members, designated representatives, and/or staff shall be informed and educated about QUEST benefit coverage and protocols/processes.

PROCEDURE

1. Members are informed of their benefit coverage, availability of case management services and protocols on how to make a referral and access case management services through the following means:
    a. New Member Packet
    b. "Partners in Health" publication
    c. Customer Service

2. QUEST Case Management Associates (CMAs) and nurses are located in various clinics. They are available to assist members and to convey QUEST benefit coverage and protocols/processes. The CMAs' names, phone numbers and office locations are included in the new member letters.

3. Members receive an annual reminder of EPSDT requirements in Kaiser's "Partners in Health" publication that is mailed to Kaiser members on a quarterly basis.

4. A Care Coordinator is identified and is assigned to members who require case management services. The Care Coordinator is the primary contact person who keeps the member informed about the benefit coverage and protocols/processes.

5. Kaiser physicians and staff are informed of QUEST benefit coverage, and protocols/processes at orientation, department meetings, and via Kaiser's intranet, newsletters and email.

6. Kaiser QUEST staff are informed of new information or changes in QUEST benefit coverage and protocols/processes at regularly scheduled staff meetings.

ENTITY/DIVISION

QUEST/GOVERNMENT PROGRAMS

Policy #: 6547-02-11
Original Date: 11/23/01
Revision Date: 03/22/10

SUBJECT & TITLE

DISCONTINUING CASE MANAGEMENT SERVICES

COVERAGE

QUEST MEMBERS

RESPONSIBILITY

QUEST Case Management Staff

POLICY

Case management services will be terminated upon successful completion of the member's care plan interventions or as identified in the procedure.

PROCEDURE

1. The Care Coordinator will reassess the member's health status and consult with the referral source, member/designated family member/caregiver and PCP to determine if case management services should be discontinued.

2. The Care Coordinator will close the case when:
   a. Interventions have been successfully implemented.
   b. Member is stable and able to function independently or appropriately with the support of the family member/caregiver or resources.
   c. Member declines care coordination
   d. Member is no longer a Kaiser QUEST member
   e. Care Coordination completed
   f. CPS worker acquires case
   g. Disease process is controlled and managed medically by a provider
   h. Member is compliant w/medical regimen
   i. Barriers to care are resolved
   j. Member demonstrates understanding of health education
   k. Member is linked to community-based services

3. The care planning process may be restarted at any time for the same or new problem/disease.

4. If member changes health plan, the case manager will provide the new health plan with pertinent information to assist in transitioning the member to the new health plan.

ENTITY/DIVISION

QUEST/GOVERNMENT PROGRAMS

Policy #: 6547-02-12
Original Date: 11/23/01
Revision Date: 03/22/10

SUBJECT & TITLE

DOCUMENTATION OF CASE MANAGEMENT ACTIVITIES

COVERAGE
QUEST MEMBERS

RESPONSIBILITY
QUEST Outreach Nurses

POLICY
Documentation of all care coordination/case management activities is made at every level of the case management process.

PROCEDURE

1. Documentation is made by case management staff assigned to carry out specific responsibilities.

2. The documentation is made at all four stages of the Case Management Process:
   Stage One: Assessment
   Stage Two: Planning
   Stage Three: Implementation
   Stage Four: Evaluation

3. Documentation of all case management activities, including any consultations, interactions, case conferences, referrals, revisions, correspondence and other activities related to the case management services is made in the members' electronic health record.

4. The status of all cases is maintained on a department tracking sheet.which is accessible to all case management staff.

5. The Care Coordinator uses the Needs Assessment, Initial Assessment, and Individual Care Plan (ICP) procedure; and electronic health record charting system to document at various stages of the case management process.

6. Case Manager Associates (CMA) are assigned to assist the Care Coordinator with appointment tracking. The CMAs are responsible to document their interactions with the health care team and patients in the electronic health record.

ENTITY/DIVISION

QUEST/GOVERNMENT PROGRAMS

Policy #: 6547-02-14
Original Date: 11/23/01
Revision Date: 03/22/10

SUBJECT & TITLE

INDIVIDUAL CARE PLAN

COVERAGE

QUEST MEMBERS

RESPONSIBILITY

QUEST Outreach Nurses

POLICY

An Individual Care Plan (ICP) is prepared after the completion of the Needs Assessment and Initial Assessment forms. The ICP addresses the problems identified. Expected Outcomes and interventions are developed.

PROCEDURE

1. An Individual Care Plan (ICP) is completed for each member who is identified as high risk.

2. The Care Coordinator is responsible for providing the following information on the ICP form:
    a. *Presenting Problem* – The problems identified are prioritized.
    b. *Expected Outcomes* – The goals relate to the presenting problem and the preliminary discharge outcome.
    c. *Interventions* – The interventions are appropriate to the member's needs, reflective of the member's age, reflective of the member's understanding and responsive to the member's disabilities, medical condition and/or coexisting conditions.
    d. *Assigned Care Coordinator* – The primary care coordinator either provides the service or coordinates the service delivery that is needed by the member.

3. The member must agree with the plan indicating the he/she consented to and participated in the development of the care plan.

4. The Care Coordinator signs the ICP.

5. The Care Coordinator will document interventional effectiveness and/or revisions related to the member's condition. Evaluation of the ICP is ongoing until case closure.

HIGH RISK CRITERIA PROTOCOL

TYPES OF CASES	REASON TO OPEN CASE **may include:** • **referral from Health Care Team,** • **SHCN assessments, or** • **Computer Chart review reveals pt needs care coordination, or** • **reasons listed below** • **case will not be opened if unable to contact pt , or interventions are already in place**	REASON TO CLOSE A CASE **may include:** • **patient declines care coordination, or** • **pt is no longer a Kaiser QUEST member, or** • **reasons listed below**	COMMENTS
Lead	• Referral from a Health Care Team member or an abnormal Blood Lead Level > 10	• Two consecutive Blood Lead Levels < 10	Provider may require monitoring until level <5
CPS	• Referral from Health Care Team provider stating that care coordination may be necessary OR • As identified by a Health Care Team member upon chart review that care coordination is necessary	• Care Coordination completed OR • CPS worker acquires case management	
Complicated Medical Conditions • **Diabetes**	Based on disease processes, patient may require: • Identification of barriers to	• Coordination of care completed OR	

• **Heart Disease** • **Asthma** • **Renal Disease** • **Cancer** • **Chronic Obstructive Lung Disease**	accessing care OR • Health Education OR • Coordination of care needed for medical care or community resources OR • Follow-up if pt was Hospitalized or had ER visits of more than 3x in the last year for one of the mentioned diseases and/or had no out patient visit f/u post Hospital/ER discharge	• Disease process is controlled and managed medically by a provider OR • Pt compliant w/medical Regime OR • Barriers to care resolved OR • Pt demonstrates understanding of health education	
Prenatal High Risk	• Referral by a Health Care Team member stating that assistance is needed for prenatal appts • Coordination of care between 2 or more providers	• Pt attends at least 3 prenatal appts within the first 6 mos of pregnancy OR • Is compliant w/ prenatal care through 36 wks gestation OR • OV q1-2 weeks during the last 8 weeks prior to EDC OR • Baby is born and mother attends first post partum appt	

High Risk Infants	• Infant will require care coordination of 2 or more providers or community agencies	• Parents are compliant with provider's plan of care OR • Community –based service initiated (ie-Healthy Start, PHN, 0-3 referral)	
Developmental Delays	• No community–based services provided • >2 Failed specialty appts	• Linked to community-based services • Appt tracking referred to CMA for determined time period	
Behavioral Health diagnosis	• Requires care coordination between PCP, BHS provider, CCS provider, and/or DOE	• Care established with BHS provider OR • NS to appts w/o rescheduling x2;Unable to contact pt AND letter is sent	
Pain Management	• Frequent requests for medication refills OR • Frequent ER visits for pain/meds OR • No MD office visits but continues to request for pain meds	• Pt has established pain control regimen (i.e. has contract with PCP, attends substance abuse treatments, attends Pain Clinic) .	

KAISER PERMANENTE®

Section 80.325

Member Services

(18 pages maximum)

80.325.1 Member Services Narrative -General Member Services

The applicant shall describe:

A. How it will review and update members' annually on changes to their member handbook;

The member handbook will be reviewed and revised annually as needed. In addition to receiving a new member packet upon enrollment, members will be issued a handbook annually.

B. How it will ensure that all members information provided or sent to members is written at a grade school level of 6.9 or lower as described in Section 50.430;

Kaiser Permanente uses the Flesch-Kincaid Index to ensure that all member materials are written at a grade school level of 6.9 or lower.

C. How it will assure interpretation services are available to members that speak a language other than English as their primary language; and

Language assistance services are provided 24/7 at all points of care at no cost to the member. Interpretive and translation services are provided by contracted vendors. Vendors will assure competency and provide documentation of individuals providing interpretive and translation services. A master list of approved contractors is maintained. Contracts are reviewed annually and revised/approved as deemed necessary. For written materials, the contracted vendor must also certify that a qualified individual has reviewed their translation for accuracy. Periodic data on the demographic and cultural profile of the

community and plan membership are collected and a needs assessment done to plan and implement services that respond to the cultural and linguistic characteristics of the service area.

D. How it will notify members of the availability of oral interpretation services as required in Section 50.495.

The Kaiser Permanente QUEST Member Handbook, Guide to Services for Hawaii QUEST Members, has a cover page(s) dedicated to informing members about the availability of interpretive services. These services are provided to our members at no charge. A language block is also included with all member materials informing members of the availability of interpretive services and how to access the service. Member Rights and Responsibilities posters in all Kaiser Permanente clinic lobbies offer the right to obtain language interpretation. There is also an interpretation services brochure available in all clinics.

80.325.2 Member Services Narrative -Toll-free Call Center and Twenty-Four Hour Nurse Line

The applicant shall provide a comprehensive description explaining how it will operate the required toll-free call center and nurse line. At a minimum, the applicant shall describe for both the call center and the nurse line:

A. Its training curricula and schedule for training call center staff for both the call center and the nurse line, including ongoing training and training when program changes occur;

Kaiser Permanente has a QUEST-specific call center located in Hawaii for members, providers and staff. Call center staff are part of Kaiser Permanente's Government Programs (QUEST) department thereby enabling training to be specific to the QUEST program and

performed at any time (twice a year, at a minimum). Oversight of the call center staff is provided by the Government Programs Manager. The standard training curricula for the QUEST call center includes, but is not limited to:

- Medicaid compliance training
- Orientation to Med-QUEST (review of each division and their function)
- How to check eligibility (Kaiser Permanente and DHS systems)
- Review of the member handbook (including benefits and services, how to file complaints, grievances and appeals, how to obtain language assistance services, how to request non-emergency transportation services, etc.)
- Review of the Provider Directory & Affiliated Care Provider Listing
- Review of Med-QUEST's website
- How to report change of information to Med-QUEST
- General customer service skills

In addition to the standard training curricula and updates during monthly staff meetings, ad-hoc training is performed as DHS rules and/or Kaiser Permanente policies change.

The toll-free call center is staffed from 7:45 a.m. to 4:30 p.m. (Hawaii Standard Time), Monday through Friday, excluding State holidays. When the call center is closed, callers may leave a message to be returned by close of business the following business day, or call Kaiser Permanente's main switchboard to have a staff person paged for urgent issues. This means that members have access 24/7 to these services.

There is also a regional toll-free Nurse Advice Line available at all times for Kaiser Permanente members. Registered nurses provide health care advice using established guidelines approved by physicians. Using the nursing process, callers are assessed and triaged for a wide variety of health problems and concerns. Urgent and routine advice as well as self-care at home is provided. Critical thinking and sound nursing clinical judgment, in conjunction with approved clinical guidelines that provide decision support, are utilized when providing health care advice.

1. Health care advice protocols/guidelines are selected and/or developed and maintained jointly by the members of the Regional Advice Management Team in partnership with medical, nursing, and other appropriate health care professionals using current standards of practice.
2. A program of orientation, training, competency assessment, and continuous staff development is provided for all staff involved in the health care advice process.
3. Health care advice is documented in the patient's electronic medical record according to established standards including history of present illness, demographic information, assessment, plan of care, implementation plan, and evaluation.
    - Documentation is completed in accordance with current advice documentation procedures.
4. All health care advice encounters, practices, settings, and personnel are subject to applicable external requirements and existing internal policies and procedures governing the organization.
5. Quality management processes are applied to the health care advice practice to continuously improve its processes and outcomes and shall include at a minimum:
    - Ongoing, documented monitoring and evaluation of health care advice calls in accordance with advice audit standards established by the Kaiser Permanente Interregional Nursing Council,
    - Performance measures on health care advice access standards established by the organization, and
    - Other quality indicators determined by the advice management team or the organization.
6. Oversight of health care services shall be provided by an advice management team consisting of the medical advisor for health care advice, nursing practice leader(s) or designee, the telephone call processing consultant, the health care advice supervisor, advice registered nurses and other representatives as appropriate to effectively manage health care advice.
    - The advice management team shall recommend provision of sufficient financial, technological, and clinical support to ensure the delivery of quality, efficient, safe, and cost effective health care advice in a safe, ergonomic, and efficient work environment, to include virtual offices.

B. How it will route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring calls to supervisors or managers;

Due to Kaiser Permanente's integrated system of providing care and having QUEST specific staff available in the clinics to assist members with inquiries, the volume of calls received by the QUEST call center is relatively low. We have been successful in servicing callers with one staff person, as evidenced by our high scores in customer service surveys conducted by Med-QUEST. We review the number of calls received, the number of voice messages on the answering machine, and the types of calls received. We have three additional staff that can assist the call center during the Annual Plan Change Period when we experience a large influx of new members, or at other times.

To ensure the accuracy of responses to inquiries, we conduct staff training twice a year and as needed. Call center staff are instructed to only answer questions within the scope of their position and to ask one of the administrative staff or the manager when unsure of how to respond.

Calls may be routed to supervisors or managers as needed based on the caller's request or staff's inability to answer the caller's question. If a supervisor or manager is not available a message will be taken and the call will be returned as soon as possible but no later than the end of the next business day.

For the Nurse Advice Line, average speed to answer and abandonment rate are captured. Additional telephone metrics are expected to be available before the end of the year.

C. How it will ensure that the telephone call center and nurse line staff can handle calls from non-English speaking callers and from members who are hearing impaired, including the number of hotline staff that are fluent in one of the State identified prevalent non-English languages; and

Kaiser Permanente has guidelines in place for individuals who need assistance with interpretive services. All Kaiser Permanente employees are educated on the guidelines and how to access service vendors for language, hearing, speech and visual interpretation. There are no call center staff fluent in any of the State identified prevalent non-English languages.

D. How it will monitor compliance with performance standards outlined in Section 50.480 and what it shall do in the event those standards are not being met.

Call center compliance with performance standards will be monitored through monthly tracking sheets. The tracking sheets indicate the types and frequency of calls received for the month. The tracking sheets will be reviewed and trended by the department manager. Staffing will be adjusted to address activities significantly affecting the call center such as open enrollment.

For the Nurse Advice Line, average speed to answer and abandonment rate are captured and staffing is adjusted to address the call volume. Additional telephone metrics are expected to be available before the end of the year.

80.325.3 Member Grievance System Narrative

The applicant shall provide a narrative describing the member grievance system it is currently using in Hawaii or another state. In your narrative, please provide:

A. A description of how the applicant determines a grievance to include but not limited to customer service calls or calls to other health plan personnel;

Grievances are any expression of dissatisfaction and are accepted by any Kaiser Permanente employee. Grievances may be filed about any matter other than an action. Members can submit a grievance by phone, in person and in writing via our “Let Us Hear

From You" forms (LUHFY), letters or email at www.kp.org.

Members or the member's representative may file a grievance. Providers are also able to file a grievance on behalf of the member orally or in writing with a written consent from the member or their authorized representative.

B. An explanation of how member grievances and appeals are tracked and trended;

Member grievances are processed through the Customer Feedback System (CFS), a decentralized, automated, Lotus Notes database system that captures the spectrum of verbal and written member concerns. Trained staff have access to the system and able to enter a member's grievance directly into the CFS.

Local Accountable Groups (LAG) are the entities responsible for the delivery of quality patient care and member service in a particular department. The supervisory staff of the LAG involved in the reported situation is required to contact the member by phone or letter to resolve the concern. The CFS provides monitoring and tracking for the period that the case is open. The case is closed in the system when the responsible person makes the desired member contact to resolve the issue and the resolution actions are documented in the CFS. The CFS will track the number of days to resolution.

The CFS Administrator will provide to Local Accountable Groups and the Quality Information Team a quarterly report of the number and category of grievances. The data will be reviewed and analyzed for trending of problem areas in care and service.

The Quality Metrics Department has access to CFS and reviews all cases for Quality issues, referring appropriate cases through the Quality Review process. The Risk Management Department also reviews cases with potential risk implications, as well as those with confidentiality issues, which are forwarded for assessment by the Regional Confidentiality Committee. Data from multiple database files is available for reporting, trending, and initiation of appropriate care delivery and service improvements. CFS Administration

distributes weekly, monthly and annual tracking and trending reports to Senior Leadership, Department Chiefs, Physicians-in-Charge, and Managers, as well as periodic reports to regulatory agencies. CFS Administration also provides trending data to the Quality Information Team (QIT) semi-annually. The QIT uses the data in conjunction with other satisfaction measures to determine top issues for Regional improvement interventions.

Appeals are tracked through electronic records created in an MS Access-based database. A record is created for an appeal at each level of processing. The record contains 56 individual data fields that are manually completed by appeals staff. Data fields capture demographic, case specific, decision making, and timeliness information. The data processing function in Access permits the appeals office to collate information in the database and generate reports.

Appeals are trended through reports generated from data contained in an MS Access-based database. Various reports are generated on a monthly, quarterly, biennial, and annual basis. The appeals office variously trends appeals by processing timeliness, volume, product line, appeal subject type, review level, and decision outcome. The appeals office also trends special subjects when requested by the organization. The CFS Administrator and the Appeals Manager report annually in the Quality Management Program Evaluation the accomplishments and opportunities for improvement.

C. A description of the training provided to staff who handle member grievances and appeals;

Designated staff members who handle member grievances are trained to use the CFS system and are provided a training manual which provides a detailed overview of the system and its functionality. The manual includes instructions on how to document a grievance, any follow-up and the resolution in the CFS system. The Grievance Policy is also reviewed which outlines the requirements of this RFP. In addition, the CFS Administration team monitors concerns on a daily basis for content, timeliness and other QUEST requirements. Follow-up is done on an individual basis if requirements are not being followed.

Appeals staff members are trained at the time of hire and on an on-going basis as rules and regulations are updated or changed. Training takes place in person, by electronic mail, handouts, and at departmental or organizational meetings.

D. A description of how staff performance and operational processes are monitored and adapted to ensure compliance with member grievance system requirements to include but not limited to meeting required timeframes identified in Section 51.100.

To ensure timeliness of resolving grievances the CFS Administrator will notify managers via a weekly emailed report of aging cases. The report details the timeliness to alert them of the approaching 30 day timeframe. Grievances that have exceeded the 30 day threshold are reported to the department specific Senior Manager. The reports produced by the CFS Administrator, enables managers to monitor their staff's attentiveness to the timely processing of grievances.

The appeals department staff's performance is monitored on an ongoing basis by the appeals manager through the review of completed files. Any identified concerns are immediately discussed with staff. The manager queries staff on an ongoing basis about their working knowledge of processing requirements and reiterates information as needed. Written policies are provided to and discussed with staff as changes occur.

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Section 80.330

Quality Assessment and Performance Improvement (QAPI)

(36 pages maximum)

80.330.1 QAPI Program Narrative – QAPI Program

The applicant shall provide the following information relative to the QAPI program:

A. Governing body accountable for providing organizational governance of the QAPI program, a description of the governing body's responsibilities, description of how it exercises those responsibilities, and the frequency of meetings.

The Kaiser Foundation Health Plan, Inc. (Health Plan)/Kaiser Foundation Hospital (Hospital) Boards' of Directors, comprised of health care, industry, and community leaders, has the ultimate accountability and responsibility for the quality of care and service provided for the Hawaii Region, and all Kaiser Permanente regions across the country. To exercise this responsibility, a Board subcommittee, the Quality and Health Improvement Committee (QHIC) was established to oversee quality of care and service across all KP programs on its behalf. The QHIC meets four times a year and reports its decisions, actions and recommendations to the Health Plan and Hospital Boards of Directors, at least quarterly. The QHIC is accountable to:

- Provide strategic direction for quality assurance and improvement systems.
- Provide oversight of systems designed to ensure that quality care and services are provided at a comparable level to all members and patients throughout the Kaiser Permanente Program across the continuum of care.
- Provide oversight of the Kaiser Permanente Program's quality assurance, health improvement systems and organizational accreditation and credentialing.

Annually, QHIC reviews and approves the Region's quality program description, work plan and evaluation. The Region submits Quality Committee meeting minutes and other reports

as requested to the QHIC. The Senior Vice President of Quality sends written follow-up letters to the President and the Executive Medical Director describing Region-specific requests for clarification and/or recommendations for action. QHIC communication to the Region also includes a summary of discussions and decisions by the Board and comments on the Region's follow-up actions from previous recommendations.

The QHIC and Hawaii Permanente Medical Group, Inc. (HPMG) Board of Directors hold the Hawaii Region's Health Plan and Hospital President and HPMG Medical Director accountable for the effectiveness of the Hawaii Region's quality program. The President and Medical Director assign day-to-day quality management activities to the HPMG Associate Medical Director (AMD) for Quality Improvement and the Health Plan Vice President (VP) of Quality, Service, and Safety as the designated Senior Quality Leaders for the Hawaii Region. The Senior Quality Leaders co-chair the Regional Quality Committee (QC) and the Quality Information Team (QIT). The HPMG AMD for Quality Improvement and the Health Plan VP President for Quality, Service, and Safety co-chair the Region's governing Quality Committee, which provides direction, oversight, coordination, and communication of the Hawaii Region Quality, Patient Safety and Service priorities, activities, and performance.

Hawaii Region Quality Structure

The Hawaii Region Quality Program is structured to enable Health Plan, Hospital, and HPMG to provide optimal quality and continuity of medical care and service to members. The quality structure establishes accountability through the HPMG AMD for Quality Improvement and the Health Plan VP of Quality, Service, and Safety.

The HPMG AMD for Quality Improvement and the Health Plan VP of Quality, Service, and Safety co-chair the Regional Quality Committee and the Quality Information Team and assume ultimate responsibility and accountability for the direction, implementation, and success of the program. Sharing accountability is Director, HPMG and Clinic Administration for ambulatory quality and the Director of Quality, Accreditation and Licensing for the Hospital, both formal members of the Quality Information Team and the Quality Committee.

The HPMG AMD for Quality Improvement is the designated senior physician accountable for implementing an ongoing Quality Program including accountability for resource stewardship and clinical risk management. The AMD for Quality Improvement assigns accountability for quality improvement to each operations medical group leader through planning, design, implementation and review.

B. The committee/group responsible for developing, implementing and overseeing QAPI Program activities/operations. See pages 453-454 for details on required information.

1. A description of the committee's specific functions/responsibilities, how it exercises these responsibilities, how it exercises these responsibilities, and the frequency of its meetings;

The Regional Quality Committee meets a minimum of eight times per year to provide direction, oversight, coordination and communication of the Hawaii Region Quality, Patient Safety and Service priorities, activities, and performance. The role of its members is to ensure quality objectives and work plan tasks are accomplished as well as to ensure that strategic quality goals are met. The QC, via the Quality Information Team (QIT), sponsors local quality improvement (QI) initiatives. The membership term of the Quality Committee is indefinite.

Quality Committee deliberations, decisions, and actions are documented through contemporaneous minutes. In general, meeting minutes are reviewed and approved by members at the subsequent meeting. Unresolved issues are tracked through resolution with an issues tracking log. Agendas and meeting minutes are retained by the official recorder and signed off by the chair(s).

The Quality Committee serves as the Region's quality oversight committee has the authority and responsibility to review and act on the following:

- Quality Assurance/Improvement
- Resource Stewardship

- Patient Safety
- Member Satisfaction[1]
- Member Grievances / Complaints / Appeals data
- Clinical Practice Guidelines
- Regulatory (State and Federal) and accreditation issues and reviews
- Practitioner Performance (including credentialing and privileging)
- Laboratory, Diagnostic Imaging and Pharmacy (inpatient/outpatient)
- Nursing – Advice nursing and other
- Home Health
- Behavioral Health – Services/Access/Standards
- Contracted Care / Network Reports

Other oversight accountabilities for the Quality Committee include:

- Development and implementation of Regional quality, patient safety and service performance improvement programs.
- Analyses and evaluation of results of quality, patient safety and service performance improvement activities, take needed actions and ensure follow-up, as appropriate
- Identification of opportunities to improve in clinical effectiveness / service / patient safety goals and initiatives
- Recommendation of policy decisions
- Ensuring practitioner participation in leading the Quality, Patient Safety and Service priorities
- Communication of results of clinical effectiveness / patient safety / service activities to leadership and other committees

The Quality Committee is directly accountable to the Regional Executive Team (RET) with monthly reports on Committee actions and recommendations.

[1] Includes CAHPS, HCAHPS, Meteor, CFS, etc.

2. A description of the composition/membership of this committee, including information on:

- **The chairperson(s) – including title(s), and for physicians, provide specialty;**

  The Quality Committee is co-chaired by Susan Murray, Regional Vice President for Quality, Service and Safety and James Griffith, M.D., HPMG AMD for Quality Improvement and Professional Chief of Hospital Staff (specialty – Pulmonary Diseases).

- **Physician membership – including the total number and types of specialties represented;**

  As of October 2011, there are twelve (12) physicians on the Quality Committee – eight of which are primary care physicians in Family Practice, Internal Medicine and Pediatrics. There are four specialty care physicians in Radiology, Infectious Disease, Pathology, and Behavioral Health.

- **The physician designated to have substantial involvement in the QAPI Program; and**

  The President and Medical Director assign day-to-day quality management activities to James Griffith, M.D., HPMG AMD for Quality Improvement and Professional Chief of Hospital Staff as the designated physician substantially involved in the QAPI Program.

- **The licensed behavioral health care practitioner designated to be involved in the behavioral health care aspects of the QAPI Program.**

  Linda Balazs, Behavioral Health Services Regional Manager and Dr. John Draeger, HPMG Behavioral Health Services Chief who is a licensed behavioral health practitioner

are involved in the behavioral health care aspects of the QAPI Program and a member of the Quality Committee. In addition, designated behavioral health practitioners serve on other committees including the Pharmacy and Therapeutics Committee and the Practitioner Performance Review Oversight Committee.

3. The applicant's staff membership – including names and position titles.

- Susan Murray, Regional VP for Quality / Service and Safety
- Barbara Kashiwabara, Director, Pharmaceutical Services (Ancillary Strategic Planning)
- Brian Cody, Director, HPMG and Clinic Admin (QM clinics, service)
- Gayle Seifullin, Director of Accreditation and Licensing, Quality Clinical Risk & Credentials
- Hong Min, Director Business Operations Consulting
- Linda Puu, Associate Chief Nursing Officer
- Jill Shinno, Director, Clinic Operations (Ambulatory Nursing, Population Care)
- Larry Shima, Director, Regional Lab Services
- Les Chock, Regional Infection Control Manager
- Linda Balazs, Manager, Behavioral Health Services
- Lynette Wong, Acting Regional Compliance Officer
- Liza F Villanueva, Executive Director & Administrator for Continuing Care and Ancillary Services
- Robert Diaz, Administrative Director, Diagnostic Imaging
- Sally Lee, Director, Specialty Care Services, Research and Grants, and New Ventures
- Sarah Neal-Fujimoto, Director, Clinic Operations (Diversity, Compliance)
- Susan Wilson, Quality Management Program Manager (QM, NCQA)
- Bill Haug, Hospital Administrator
- Eric Tom, Labor Management Partnership

C. A description of how applicant ensures that practitioners participate in the QAPI

Program through planning, design, implementation and/or review.

All clinical chiefs have dedicated administrative time and have the responsibility to manage the quality in their areas of accountability. Each clinical department has a physician who is the Quality Assurance liaison responsible for peer review for their department. In addition, physicians are involved in clinical practice guideline development and review processes as well as review of Utilization Management criteria.

In addition to participation on the Regional Quality Committee as described above, physicians participate on quality improvement projects and quality sub-committees. Examples of physician involvement on quality sub-committee are as follows:

Committee/ Sub-committee	Function and Role	Physician Involvement
Regional Quality Committee	Serves as the Region's quality oversight committee with authority and responsibility to review and act on the following: - Quality Assurance/Improvement - Resource Stewardship - Patient Safety - Member Satisfaction - Member Grievances / Complaints / Appeals data - Clinical Practice Guidelines - Regulatory (State and Federal) and accreditation issues and reviews - Practitioner Performance (including credentialing and privileging) - Laboratory, Diagnostic Imaging and Pharmacy (inpatient/outpatient) - Nursing – Advice nursing and other - Home Health - Behavioral Health – Services/Access/Standards	(12) physicians: (8) primary care physicians in Family Practice, Internal Medicine and Pediatrics; (4) specialty care physicians in Radiology, Infectious Disease, Pathology, Pediatric Pulmonology, and Behavioral Health.

Committee/ Sub-committee	Function and Role	Physician Involvement
	- Contracted Care / Network Reports Other oversight accountabilities for the Quality Committee include: - Development and implementation of Regional quality, patient safety and service performance improvement programs. - Analyses and evaluation of results of quality, patient safety and service performance improvement activities, take needed actions and ensure follow-up, as appropriate - Identification of opportunities to improve in clinical effectiveness / service / patient safety goals and initiatives - Recommendation of policy decisions - Ensuring practitioner participation in leading the Quality, Patient Safety and Service priorities - Communication of results of clinical effectiveness / patient safety / service activities to leadership and other committees	
Regional Service Council	The Service Council is responsible for development and oversight of an integrated regional service strategy that provides focus and transparency on members' service experience. Success will be measured by the ability to maintain membership and by HCAHPS and CAHPS survey scores.	(3) physicians: primary care
Quality Information Team	The QIT is a sub-committee of the QC accountable for monitoring and tracking quality performance measures for the Committee. Initiatives that align with the Region's quality goals are reported in to the QIT through designated liaisons and leaders. The QIT's role is to identify initiatives that are not timely or	(2) physicians: (1) specialist -pediatric pulmonology (1) primary care

Committee/ Sub-committee	Function and Role	Physician Involvement
	meeting targets and provide guidance and coordinating assistance from other areas. In addition, the QIT assists areas to define performance indicators and monitor outcomes and progress.	
Quality Improvement Medical Group Committee	The QIMED Committee, a peer review committee, is a decision making body, which functions to provide the inter-rater review oversight for the peer review processes in the Hawaii Region. This work is organized to optimize and enhance measurable reduction of clinical risk and/or improvement of patient safety and quality outcomes in prioritized areas. Responsibilities - The QIMED Committee's function is to provide peer review resources in order to ensure an appropriate peer review body for impartial review. Their responsibilities include the following objective & outcomes: Objectives: - Ensure that the peer review process is impartial - Prioritize identified risk areas in clinical peer review, - Monitor effectiveness of clinical peer review as an organization, - Escalation to Practitioners Performance Review and Oversight (PPRO) Committee, if warranted Outcomes: - Improved communication of "learning's" - Enhanced reduction of barriers to prevent future occurrences of events. - Increased knowledge of methodologies, including techniques for communication adverse outcomes to	(45) physicians: (10) primary care physicians in Family Practice, Internal Medicine, OBGYN and Pediatrics; (35) specialty care physicians in Anesthesiology, Behavioral Health, Cardiology, Critical Care, ENT, Emergency Medicine, Gastroenterology, General Surgery, Geriatrics, Hematology-Oncology, Hospitalist, Infectious Disease, Nephrology. Neurology, Neurosurgery, Occupational Health, Ophthalmology, Optometry, Orthopedics, Otolaryngology, Pathology, Pediatric Pulmonology, Physiatry, Plastic

Committee/ Sub-committee	Function and Role	Physician Involvement
	departments	Surgery, Pulmonary Medicine, Radiology, Rheumatology, Urology and Vascular Therapy
Credentials and Privileges Committee	The Credentials and Privileges Committee is a peer review committee that sets the vision, goals, priorities, outcome, scope, and performs oversight and provides support for Hawaii to optimize and enhance the peer review process for credentialing and privileging of practitioners and providers in Kaiser Permanente Hawaii program. Peer Review Functions: - Recommend/approve affiliated, pro tem, staff, AHP Behavioral Health practitioners, and all Providers for the Hawaii program. - Recommend/approve privilege and proctoring processes. - Review and approval of delegated credentialing and revisions as appropriate. - Annual review and recommendation for revision of credentialing and privileging policies and procedures. - Oversight of implementation of credentialing and privileging policies and procedures. - Oversight and management of credentialing and privileging data base. - Communication and review of local C&P committee processes. - Ongoing monitoring of sanctioned activity. - Recommendation and oversight of quality indicator	(8) physicians: (2) primary care physicians in Family Practice and OBGYN (6) specialty care physicians in Anesthesiology, Emergency Medicine, General Surgery, Hospitalist, Neurology, and Radiology.

Committee/ Sub-committee	Function and Role	Physician Involvement
	reporting process. - Oversight of Medical Board/NPDB-HIPDB reporting. - Establish linkage between contracting/claims for purposes of ensuring that practitioners and providers are credentialed to see our members. - Oversight of survey results and corrective action taken within scope.	
Practitioner Performance Review Oversight Committee (PPRO)	The PPRO Committee is a Hawaii Permanente Medical Group (HPMG) peer review committee which recommends standardized physician performance measurement and performance action to the Executive Committee of the HPMG. Membership of the Committee include, Clinical Professional Chiefs, Physicians-In-Charge (PIC's), and the President of Hospital Staff. Responsibilities of the PPRO Committee include: - Analyze aggregated reports for: performance evaluations, ensure that processes are in place to identify and when to appropriately act on quality and safety issues, - Sponsor proactive monitoring and evaluation projects utilizing appropriate methodologies, - Communicate high-risk patterns and priorities, and escalation when warranted in order to fulfill objectives, - Promote risk prevention/patient safety, - Oversee the compliance with regulatory standards Outcomes: - Increase *PATIENT AND QUALITY OF CARE AND SERVICE*	(32) physicians: (13) primary care physicians in Family Practice, Internal Medicine, OBGYN and Pediatrics; (19) specialty care physicians in Behavioral Health, Cardiothoracic Surgery, Emergency Medicine, General Surgery, Infectious Disease, Neurology, Occupational Health, Ophthalmology, Orthopedics, Pathology, Radiology and Vascular Therapy

Committee/ Sub-committee	Function and Role	Physician Involvement
	- Improved communication of "learning's" - Collective *IMPROVEMENT OF PRACTITIONERS PERFORMANCE*	
Pharmacy and Therapeutics (P&T) Committee	The P&T Committee is responsible for the development and surveillance of medication therapy and utilization policies and practices in the Region. The Committee promotes excellence in medication therapy outcomes and clinical results, while minimizing the potential for adverse events. Functions of the P&T Committee include: - Reviewing, evaluating, and maintaining a formulary of medications and biologicals, based on evidence. - Measuring performance related to the use of medications, biologicals, and diagnostic testing materials, including the processes for; 1) procurement, storage, and handling, 2) prescribing and ordering, 3) preparation and dispensing, 4) medication administration, and 5) monitoring of medications. - Reviewing and approving evidence-based procedures, preprinted orders and forms, medication guidelines and protocols, and practices that promote the safe, effective and medically necessary use of medications. - Reviewing and recommending policies for HEC and QC approval. - Reviewing reports of adverse medication events including medication errors and adverse drug reactions, and making recommendations to improve medication use processes to prevent and avoid adverse events.	(11) physicians: (5) primary care physicians in Internal Medicine, Family Practice, OBGYN and Pediatrics; (4) specialty care physicians in Infectious Disease, Nephrology, Urology and Hospitalists

Committee/ Sub-committee	Function and Role	Physician Involvement
	- Evaluating and communicating clinical data concerning new medications and their therapeutic uses. - Developing and coordinating medication use evaluation activities. - Establishing standards and approving protocols concerning the use and control of investigational medications and of research in the use of approved medications. - Advising and making recommendations to the Benefits Committee on benefit coverage issues involving medications and biologicals. - Advising and educating the Professional Staff on matters pertaining to the selection of available medication therapy. - Coordinating and aligning its quality and performance improvement activities with the Hawaii Region Quality Management Program.	
Regional Clinical Risk Committee	The Clinical Risk Committee is a decision making body, which sets the vision, goals, and priorities for Clinical Risk Management in the Region, to optimize and enhance measurable reduction of clinical risk and/or improvement of patient safety and quality outcomes in prioritized areas. Membership of the Committee shall be appointed by the Committee Chair as necessary and appropriate to fulfill the mission, and shall include: - Clinical Risk Coordinator - Vice President of Quality or designee - QA Liaisons (departmental identified MD)	(11) physicians: (2) primary care physicians in Internal Medicine and OBGYN (9) specialty care physicians in Anesthesiology, Behavioral Health, Gastroenterology, General Surgery, Hospitalist, Neurology, Pathology, Radiology, and Vascular Surgery.

Committee/ Sub-committee	Function and Role	Physician Involvement
	- Patient Safety Consultant (ad hoc) - SE Analyst (ad hoc) - Legal/Claims Manager (ad hoc) - HCOM (Ombudsman, ad hoc) The Chairs of the Committee shall be a physician member of the hospital professional staff and the Clinical Risk Coordinator Manager. The responsibilities of the Clinical Risk Committee include: - Oversight and evaluation of risk management activities through an interdisciplinary and organization-wide process that identifies; - Evaluation and prioritization of issues that may create a risk of harm to its members and/or staff - Coordination and development of strategies to eliminate or minimize those risks; - Education of members, staff and organizational leaders about those risks and strategies; and - Identification and minimization of events/occurrences that may present a risk of legal liability to staff and/or the organization. Objectives: - Analyze aggregated reports for risk identification: PCEs, Medical Legal Claims, Unusual Occurrences, Member Complaints, external/internal, surveys and audits, research and other sources, - Prioritize identified risk areas, - Sponsor proactive risk reduction projects utilizing appropriate methodologies including Failure Modes	

Committee/ Sub-committee	Function and Role	Physician Involvement
	and Effects Analysis (FMEA), - Monitor effectiveness of strategies/projects, - Communicate high-risk patterns, priorities and projects, - Oversee the Clinical Risk Management Program Description, Workplan and Evaluation, - Promote risk prevention/patient safety projects, - Oversee the compliance with regulatory standards including MDQR for Risk Management, - Oversee the effectiveness of risk-related teams and committees.	
Regional Resource Stewardship and Utilization Management (RS-UM) Committee	The RS-UM is Chaired by the Regional Utilization Management Medical Director. The key role of the RS-UM is to provide oversight and sponsorship of RS-UM projects. Based on the RS-UM Team Charter, RS-UM is responsible for the following: - Sponsoring resource management projects and initiatives across the continuum of care and leading efforts to ensure the rapid transfer of best practices - Oversight, direction and monitoring of resource management improvement efforts across the continuum, including clinic, hospital, and ancillary, internal/external to the Kaiser system, with a commitment to partner as operational health care leader to effect change - Reviewing, coordinating and prioritizing resource management opportunities identified by assigned committees and groups at both the operational and service area levels - Ensuring capabilities to monitor/track	(17) physicians: (6) primary care physicians in Family Practice and Internal Medicine (11) specialty care physicians in Behavioral Health, Emergency Medicine, General Surgery, Infectious Disease, Nephrology, Orthopedics, Pathology, Pediatric Pulmonology, Radiology and Vascular Therapy

Committee/ Sub-committee	Function and Role	Physician Involvement
	appropriateness of the care site, level of care, length of stay and other key indicators of over or under utilization - Implementation of prioritized projects and initiatives aligned with organizational mission, strategies, and potential added benefit to KPHI members - Establishing linkages across the organization through networking opportunities among physicians, support departments, facilities and regions - Incorporating a comprehensive strategic planning process, which ensures consistency and coordination of all regional departments, committees, and/or groups The RS-UM members represent leaders within the region that support the structure through: - Development of strong collaborative relationships with the KP Hawaii Regional Executive Team (RET) to achieve regional and divisional goals - Coordinating and communicating with other functions and/or groups such as Primary/Hospital/Specialty Care Operation Groups - Partnering with Quality, Service, Operations, Contracts, Claims, Benefits, Sales and Marketing - Assigning sub-committees, task forces, and work groups to address identified resource stewardship priorities on defined timelines. - Monitoring progress, and supporting implementation of improvement efforts - Prioritizing projects in alignment with the	

Committee/ Sub-committee	Function and Role	Physician Involvement
	organizational goals of capacity, quality, and finance - Using data to establish resource stewardship priorities for regional improvement efforts and goals	
Hospital Quality Improvement and Patient Safety Committee (QUIPSC)	The Hospital Quality Improvement and Patient Safety Committee develops and implements a hospital wide quality and patient safety program to ensure the provision of safe, effective patient care and service through ongoing monitoring, evaluation and improvement processes. It facilitates preparation of a quarterly report of the hospital's assessment and improvement activities which is reported to the HEC and submitted to the Board of Directors by the Executlive Committee.	(3) physicians: (1) primary care physician in Internal Medicine (2) specialty care physicians in Pediatric Pulmonology and Pathology

D. A description of how the applicant makes information about the QAPI program available to its practitioners and members, including a description of the QAPI program and a report on the organization's progress in meeting its goals.

On an annual basis, a Quality Program Summary document is sent to all physician staff via e-mail or via standard mail to affiliated practitioners who do not have email. The document provides information about key quality processes and includes a statement regarding the availability of the annual Quality trilogy documents including the Quality Management Program Description, Quality Management Work Plan and Quality Management Program Evaluation which describe the Quality Program structure, current quality initiatives including results, analysis of trends and progress towards goals. The annual Quality Management Program Description is also available to practitioners via the online Practitioner Manual.

A quality care summary document is also produced on an annual basis and made available to members upon request. Members are notified regarding the availability of the quality

summary in the Partners in Health member publication as well as in the member handbooks. The Quality Summary document is also available to members via the kp.org member Website.

80.330.2 QAPI Narrative – General Provisions

The applicant shall describe:

A. How it will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care.

The Hawaii Region offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health (mental health and substance abuse treatment), home health care, hospice services, rehabilitation, and skilled nursing services. Sole practitioner health care services by HPMG are offered at Kaiser Permanente owned and operated medical offices throughout Hawaii. In addition to these medical office buildings, the Hawaii Region operates a general acute care hospital, a skilled nursing facility and two home health agencies.

Majority of care and services covered by the Health Plan insurance are provided directly by HPMG practitioners at Hawaii Region managed facilities. If medically indicated services are not available within HPMG or the Hospital, contracted community practitioners and/or contract community providers (Contract Providers) are used to ensure availability of medical care and service in accordance with the Health Plan benefit agreement.

The Hawaii Region Quality Program covers all care and service and ancillary services (including contracted services) provided to all members and patients across the continuum of care. The Quality Program encompasses Hawaii Region activities aimed at assessing and improving care and services. Although the Health Plan is ultimately accountable for the quality of care and service provided, quality management and oversight is a shared responsibility of Health Plan, Hospital and HPMG. These three entities collaborate in close

partnership to provide and coordinate high quality and effective medical management for KFHP members, striving continuously to improve the care and service. The Health Plan does not delegate any quality management functions to external organizations.

Hawaii Region Quality Program monitors and evaluates significant aspects of the clinical care, member services, and administrative services provided to members. The program integrates cross-functional activities through the use of interdisciplinary teams whenever possible. The program emphasizes quality improvement activities in member care and service.

Monitoring activities are conducted and reported on a regional, clinic, hospital, health care team, and individual practitioner level, whenever possible. Important aspects of care and service in monitoring and improvement activities include, but are not limited to, appointment availability and accessibility of services, appeals/denials, appropriateness and efficiency of ancillary services, compliance and regulatory issues, continuity and coordination of care, contracted care/network, credentialing and privileging activities, cultural competency, focused studies, infection control practices, medical record documentation, member satisfaction, member concerns and grievance process, over-utilization, mis-utilization and under-utilization, patient safety, population based care/Panel support services, potentially compensable events, preventive care, quality and risk occurrences, quality control monitoring, and sentinel events.

Annually, beginning in the fourth quarter of the year, and completed in the first quarter of the following year, the QIT leads an evaluation of the prior year's Quality Program Work Plan effectiveness, reviews the Program Description, and develops an initial Work Plan for the coming year, all formally reported and approved by the Quality Committee. This annual evaluation informs Hawaii Region leadership about successes, opportunities, and gaps in meeting program implementation or established goals in the Regional QM Work Plan.

The formal evaluation process of the Quality Program includes assessment of the Region's Quality structure and processes. The Quality Committee, AMD for Quality Improvement,

Health Plan VP of Quality, Service and Safety and the QIT evaluate the performance of the Quality Program and revise the goals, initiatives, structure, or responsibilities to ensure an effective program. Quality initiatives are continuously assessed throughout the year. Quality issues are tracked and improvement efforts are documented. Improvement opportunities identified through the formal evaluation process and other assessment processes including MDQR, NCQA, the Joint Commission, Med-QUEST, CMS and DOH reviews are considered for inclusion in the current or subsequent year's Quality Work Plan.

The Quality Program Description and the Quality Work Plan are also reviewed, evaluated and amended annually. This evaluation assesses the impact of clinical care and services delivered, achievement of goals or objectives, and informs improvements to the following year's Quality Program. These three documents (QM Program Evaluation (prior year), QM Program Work Plan, and QM Program Description) are reviewed and approved by Quality Committee and submitted to the Health Plan/Hospital Boards' Quality Health and Improvement Committee (QHIC) for further review and comment.

B. The methodology to review the entire range of care provided to all demographic groups, care settings and types of services to ensure quality, member safety, and appropriateness of care/services in pursuit of opportunities for improvement on an ongoing basis.

The scope of our Quality Program encompasses all demographic areas of care settings as described in the overall Quality Management Program Description and addresses all areas of specialty including primary care, specialty care, preventive care and patient safety.

The formal evaluation of the Quality Program includes an assessment of the Hawaii Region's Quality structure and processes. The Quality Committee, Vice President for Quality, Service and Safety and the HPMG AMD for Quality Improvement evaluates the performance of the Quality Management Program and revise goals, initiatives, structure or responsibilities to assure an effective program. Quality initiatives are continuously assessed throughout the year and quality issues are tracked and improvement efforts are documented. Quality issues are tracked and improvement efforts are documented.

Improvement opportunities identified through the formal evaluation process and other assessment processes including MDQR, NCQA, the Joint Commission, Med-QUEST, CMS and DOH reviews are considered for inclusion in the current or subsequent year's Quality Work Plan.

The Quality Program Description and the Quality Work Plan are also reviewed, evaluated and amended annually. This evaluation assesses the impact of clinical care and services delivered, achievement of goals or objectives, and informs improvements to the following year's Quality Program. These three documents (QM Program Evaluation (prior year), QM Program Work Plan, and QM Program Description) are reviewed and approved by Quality Committee and submitted to the Health Plan/Hospital Boards' Quality Health and Improvement Committee (QHIC) for further review and comment.

C. The methodology and mechanisms to implement corrective actions as well as monitor and evaluate the effectiveness of corrective action plans.

Corrective actions are implemented and monitored as part of the annual evaluation process as well as from ongoing monitoring processes through the Quality Information Team and Quality Committee.

On an annual basis, the Hawaii Region assesses and reports to the Quality Committee the established availability and accessibility standards. Member survey results are also monitored on a quarterly basis also addressing member satisfaction relating to access and availability of services.

80.330.3 QAPI Narrative – Value-Based Purchasing

A. The applicant shall describe its experience with value-based purchasing (VBP) to incentivize quality and efficiency of care and improve overall health outcomes;

Kaiser Permanente QUEST does not have any value-based purchasing incentives at this time.

B. The applicant shall describe how it will implement VBP in the QUEST program, to include supporting the health home model.

Kaiser Permanente QUEST does not have any value-based purchasing incentives at this time.

80.330.4 QAPI Narrative -Performance Measures

The applicant shall:

A. Describe its policies and procedures relating to meeting HEDIS performance measures requirements; and

Our annual formal Quality Documents (2011 Quality Program Work Plan, 2011 Quality Program Description and 2010 Quality Program Evaluation) serve as the Region's formal documents addressing the use of HEDIS measures and performance goals for monitoring clinical care.

The Region identifies specific measures as high priority to provide a focus for organizational improvement for 2011. These high-priority measures are included in the 2011 Quality Work Plan and represent clinical areas in which there is a significant gap to target or where the measure represents an area of care that the Region has particularly targeted for improvement. Other ongoing measurement and monitoring are reported on to the Quality Committee and provide a broader view of organizational performance, which also includes measures required by accreditation, regulatory and governing bodies.

Analysis and reports that compare performance across the Kaiser Permanente Program as well as to national percentiles are generated and shared program-wide. We use process

and outcome data including HEDIS and information to prioritize, develop and implement initiatives to improve patient care, safety and services across the continuum.

Performance targets that include HEDIS by national benchmarks (i.e., national percentiles) and inter-regional "Best in Program" performance are identified and analyzed to local Hawaii Region performance. Interventions are designed by teams with direct and operational accountability to achieve targeted outcomes and systematic performance improvement.

B. Provide HEDIS measures for the last two (2), twelve (12) month periods from the State of Hawaii. If the applicant is not currently providing services to Medical Assistance clients in the State of Hawaii, the applicant shall submit its most recent HEDIS measures from at least two other states that it has previously or is currently operating. Please provide reference to the population reporting on to include geographic location and member demographics. The applicant shall indicate which measures were validated by an EQRO or NCQA certified compliance auditor and provide the validation reports. Note: the HEDIS measures and the validation reports do not count towards the page limit.

See attached documents in Section 80.310 - F:

- HEDIS 2010
- HEDIS 2010 Compliance Audit Final Report of Findings for Kaiser Permanente QUEST, July 2010
- HEDIS 2011
- HEDIS 2011 Compliance Audit Final Report of Findings for Kaiser Permanente Hawaii QUEST, July 2011

80.330.5 QAPI Narrative -Delegation of QAPI Program Activities

The applicant shall provide a narrative describing the functions of all activities it intends to delegate, a list of proposed delegates and its plan to monitor the delegated functions.

Kaiser Permanente does not delegate any QAPI activities for the QUEST Program.

80.330.6 QAPI Narrative -Medical Records Standards

The applicant shall provide a narrative explaining how it maintains medical records and assures appropriate record retention and how it monitors provider compliance with its policies.

Kaiser Permanente Hawaii incorporates a hybrid medical record system with active and inactive paper charts, as well as electronic medical records. Since October 1, 2006, the legal medical record for Kaiser Permanente has been KP HealthConnect®, an electronic health record (EHR) system powered by Epic Corporation software. The legacy medical record paper charts are stored in the 501 Alakawa Street facility with environmental humidity and temperature specifications as follows: temperature 40 to 120 degrees Fahrenheit, relative humidity not to exceed 85 percent, minimal airborne debris such as dust, aerosols, chemical vapors and sunlight, no exposure to water, corrosive agents, blood or blood products, fire, or other potentially harmful agents. The paper charts are accessible during regular business hours by authorized personnel only. The medical records room and elevator are secured after normal business hours. Access to the Outpatient Medical Record (OMR) and its contents is restricted to authorized Kaiser Permanente workforce only. Original medical records are not removed from KP premises unless authorized by the Regional Hospital Administrator, Regional Clinic Administrator, or pursuant to court order.

Kaiser Permanente retains active and inactive medical record charts in paper form, abiding by the following retention policy # 6440-04-07: Complete medical records for adult patients are retained for a minimum of ten (10) years after the last date of documentation entry. Complete medical records for minor patients are retained for a minimum of ten (10) years after the minor reaches the age of majority. Basic medical record information for adult patients is retained for a minimum of twenty-five years after the last date of documentation entry. Basic medical record information for minor patients is retained for a minimum of twenty-five years after the minor

reaches the age of majority. Fetal monitor strip records are retained until the age of 25 plus two (2) years for statute of limitations. Diagnostic imaging films are retained for a minimum of seven (7) years, with the following exceptions: Mammogram films are retained for a minimum of ten (10) years. Pediatric films are retained until the age of 25 plus two (2) years for statute of limitations. Written reports from the reading and interpretation of the film are retained for no less then the same duration of the images

Records may be destroyed after the prescribed retention period provided they are destroyed in a manner that renders the information unintelligible and irretrievable. Paper documents (physician copies, unconfirmed reports, Chart pulls, and appointment schedules) containing PHI is destroyed in compliance with all regulatory requirements.

Original Kaiser Permanente Hawaii photos, pictures, and graphs are scanned and the original retained in the paper chart. Documents of good scan-able quality are scanned and retained for three months, after which they are destroyed in a manner that renders the information unintelligible and irretrievable

The Legal Health Record (LHR) is periodically monitored to ensure compliance with polices, rules, regulations and accreditation standards. The results of the monitoring are reported and issues escalated to appropriate departments/committees to address, resolve, and take action if necessary. The Health Information Management (HIM) Department monitors the inpatient medical record. HPMG analytics department monitors KPHealthConnect® for provider compliance with requirements regarding review, completion and closure of open ambulatory encounters. Medical Records Administration is responsible for ambulatory administrative chart closures in Kaiser Permanente HealthConnect®.

80.330.7 QAPI Narrative – Practice Guidelines

The applicant shall indicate the practice guidelines it will select for use as part of its QAPI program.

For each guideline, also include:

A. The rationale for its relevance to the QUEST population;

The four clinically relevant conditions selected are Diabetes, Coronary Artery Disease (CAD), Depression, and Attention Deficit Hyperactivity Disorder (ADHD). The practice interventions implemented provide the most significant risk reduction for our members. Evidence based practice guidelines are developed for each of these conditions. Additional rationales for the selection are as follows:

Diabetes:

In Hawaii, the rate of people with diabetes exceeds the Healthy People 2010 target by over 300%. In this state, 8.6% of people have diabetes compared with with a 2.5% target. There is a notable higher rate of male diabetes at age 18-24 and female diabetes at age 25-34. Roughly 40% of diabetes cases before age 14 are Hawaiian. In the next age bracket, 40% of diabetes cases age 15-17 are Filipino. This rate is notably higher in Hawaiians and Filipinos in the 25-34 age brackets. A review of our Hawaii region 2010 data shows 35.96% of members with HgbA1c control below 8% and 18.41% of members with good HgbA1c control <7%. The opportunity for improvement in diabetes control is clear. Evidence based recommendations support tight glucose, blood pressure, and lipid control.

Coronary Artery Disease:

Cardiovascular diseases represent the leading cause of death in the state of Hawaii. Of this main group of conditions, Coronary Artery Disease is the highest at 73.2%. Prevalence of modifiable conditions in Hawaii adults such as obesity and smoking are 20.5% and 16.9% respectively. The Healthy People 2010 target for obesity is 15% and for smoking is 12%. Regional data review illustrates that LDL-C control<100 is 42.47% even with our improved LDL-C screening at 85.17%. There is great potential for improved outcomes with focused interventions as part of a comprehensive and integrated care delivery system.

Depression:

Nationally, the prevalence of Depression in adult Kaiser members 18 and older is 505,000. In the Hawaii region, total encounter volume from 2008-2010 for patients diagnosed with

Major Recurrent Depression was 15,455. Targeted outcomes for depression address effective treatment in the acute and continuation phases. A 2010 outcome data review shows 40.3% with effective acute phase treatment and 22.34% with effective continuation phase treatment. The opportunity for improved outcomes in the care of members with depression is evident.

Attention Deficit Hyperactivity Disorder (ADHD):

The prevalence of ADHD nationally within Kaiser members ages 6-12 is 11,100 as of 2010. The follow-up care in the initiation phase for children prescribed medication for ADHD has steadily improved from 30.77% in 2008, 51.06% in 2009, to 68.09% in 2010. Evidence based recommendations support accurate assessment, initiating appropriate interventions and therapy, and follow-up care.

B. The measures the applicant will take to increase compliance with practice guidelines and how compliance with practice guidelines will be monitored; and

Patient centered outcome data is systematically gathered, reviewed, and evaluated. Recommendations for targeted practice interventions are communicated to providers regionally through regional and departmental medical education events, professional meeting updates. Outcome measures for each of the disease conditions are listed below:

Diabetes: HgbA1c and LDL levels
CAD: Beta-blocker treatment after a Heart Attack and cholesterol management for patients with Cardiovascular Conditions (CMC) LDL-control <100
Major Depressive Disorder: Antidepressant Medication Management – Acute phase and Continuation phase
ADHD: Follow-up care for children prescribed ADHD Medication - initiation phase.

C. The process for developing, updating and disseminating practice guidelines to providers.

Kaiser Permanente's clinical practice guidelines are based on the best available clinical evidence on important health outcomes. The relevant evidence is reviewed by Kaiser Permanente Hawaii Region clinical guidelines committees, work groups or ad hoc clinical committees who advise the region on each clinical practice guideline. For KP National Guidelines, the guideline process is delegated to the National Guideline Directors Group with regional representation. The recommendations contained within each guideline are based on a systematic review of the best available evidence, as well as clinical judgment, patient preferences, and costs.

Evaluation of Clinical Practice Guidelines is ongoing. Each practice document is scheduled for regular review. This will occur on a biennial basis; or more frequently, if necessary, due to new developments in the subject area. KP Affiliated Practitioners are informed of guideline review feedback process in the Affiliated Practitioner Manual.

New and revised guidelines are distributed to all clinicians involved in the delivery of care covered by the guidelines, as well as to administrators and staff involved in supporting this care. Distribution is electronic via the Clinical Library Hawaii intranet site, supplemented by paper distribution to physicians and other practitioners not having access to the KPHI intranet.

80.330.8 Disease Management (DM) Programs Narrative

The applicant shall provide:

A. A description of its disease management program policies and procedures and mechanisms to assist members and practitioners in managing chronic conditions;

The Kaiser Permanente Care Management Institute (CMI) is a national knowledge management entity to enhance current clinical knowledge and support regional disease management programs. CMI allows us to proactively care for members with high risk, high volume chronic conditions. With participation of physicians and allied practitioners from all regions, along with evidence methodology experts, CMI is responsible for developing and

updating national KP clinical practice guidelines for major conditions. CMI incorporates knowledge of the best clinical approaches for managing chronic conditions from within and outside Kaiser Permanente, and supports integrated care management programs through a national network of implementation specialists from each region.

Kaiser Permanente Hawaii region has also added a member-based model. The goals of the model include measurable quality, whole member care, and evidenced-based medicine. The Panel Support Service (PSS) is a new model for population care which utilizes the special skills of clinical pharmacists, pharmacy technicians, advance practice RNs, medical assistants and clerical staff to help reach defined quality goals, improve the health status of patients with chronic conditions and support primary care.

The PSS team uses several tools, such as the Care Management Tracking System (CMTS) and the Panel Support Tool, to provide real time data for feedback about the quality of care as measured against regional clinical standards.

B. A description of how the applicant will administer the required disease management programs for two of the conditions listed in Section 40.802; and

Kaiser Permanente's has selected Asthma and Diabetes for its disease management program.

ASTHMA DISEASE MANAGEMENT PROGRAM

Potential for Improving Outcomes

The potential for improving outcomes is directly related to the need for medication management of persistent asthma. This is based on evidence that asthma-related morbidity and mortality is increased if asthmatic members rely on substantial use of beta-agonists with minimal or no anti-inflammatory therapy.

Additionally, it is noted that asthma education to facilitate self-management significantly reduced the risk of hospital admission, unscheduled visits to the doctor and days off work.

This was based on a systematic review of 22 randomized control trials of adult self-management.

Identifying Eligible Members with Asthma

Kaiser Permanente has the ability to identify all eligible members for the Asthma Care Management Program using a web-based population care management tool known as The Panel Support Tool (PST). The PST is supported by the Panel Management Data system, which utilizes the data gathering capabilities including information gathered from Kaiser Permanente's electronic health record, Kaiser Permanente HealthConnect (KPHC).

Identification of eligible members for inclusion in the Asthma Registry takes place automatically on a daily basis using data from the pharmacy as well as inpatient and outpatient information systems. Criteria include:

- Active members age > 1 year and ≤56 years
- Two or more asthma drugs dispensed in the last 12 months OR inpatient discharge with principal diagnosis of asthma OR clinic visit with diagnosis of asthma.

Providing Eligible Members with Information

All members have access to our KP.org website. This website provides interactive Asthma education with a comprehensive representation of topics and tools. Members may complete a health assessment that customizes their needs based upon their lifestyle choices. They have access to a schedule of classes that are available through Kaiser Permanente. The member website also boasts features allowing them to:

- refill prescriptions
- review lab results
- email his PCP for any "non-urgent" health question on a secure E-mail system,
- make future routine appointments
- procure a list of his allergies, plus information to help manage them
- receive information about his previous office visit including his vital signs, test results and follow-up details
- download, print and submit forms with updated health information to our Medical Records Department
- Link to the kp.org/healthylifestyles website

All members receive the *Partners in Health* member publication quarterly. The publication provides a schedule of available disease management support classes, including smoking cessation programs, weight-loss classes and exercise classes. Members also have access to a clinical pharmacist that will assist them in the completion of a medication history, and prescription verification. This service is targeted for our new members to assist with expedited medication transfers, minimizing breaks in medication doses.

Members may also call our Health Education Department to access pre-recorded health information including topics related to asthma management and other member publications. At our kp.org website, members have access to their own online coach, and other online programs which are personalized to support each members own self-care.

Our Pharmacy Department also provides informational flyers for members who fill prescriptions for Albuterol. The flyer is addressed to asthma members and asks them to consider two questions that would indicate uncontrolled asthma:

1. Do you use your Albuterol (or "quick relief") inhaler more than twice a week to treat asthma symptoms (not counting use before exercise)? OR
2. Do your asthma symptoms wake you from sleep more than twice a month?

By answering "yes" to either question, the flyer directs the member to contact their PCP or care manager.

For members who do not have access to the online website, clinic staff may direct members to other free books or videos, as appropriate.

Measuring Effectiveness for Asthma

Clinical indicators reflecting important elements of care promoted by the Asthma Care Management Program are measured using the HEDIS asthma management measures. Regional HEDIS reports are compared to other Kaiser Permanente regions, local competitors, and national.

DIABETES DISEASE MANAGEMENT PROGRAM

The Hawaii Region delivery system design of the Diabetes disease care model seeks to ensure the delivery of effective and efficient clinical care and self-management support. Integrated into the program design is the interface with Kaiser Permanente Care Management Institute (CMI). It is a national knowledge management entity, a resource to enhance current clinical knowledge and support regional disease management programs to proactively care for members with diabetes. The Hawaii Region has active participants which include MD's and pharmacists, along with evidence methodology experts. CMI is responsible for developing and updating national KP clinical practice guidelines for major conditions which provide the basis for disease management programs.

Kaiser Permanente's Diabetes Management Program has several important components:

- Treatment decisions based on explicit, proven Evidenced Based Guidelines researched by Kaiser Permanente's Care Management Institute (CMI)
- Empowerment of patients through self-management techniques which ensure they have a central role in determining their care, one that fosters a sense of responsibility for their own health
- Patient Support Services (PSS) Program that tracks individual patients as well as program populations of patients for both chronic illness and preventive care. This also includes condition monitoring, individual patient monitoring to adherence to treatment plans, co-morbidities and lifestyle issues such as smoking and obesity
- A Delivery System Design that is multidisciplinary, with roles and accountabilities for all team members. Members are activated by their PCP and referred to team members. Team members include pharmacists, dieticians, nurses, home care providers, medical social workers and behavioral social workers. The team, in conjunction with the member and/or caregiver, determines what care is needed, with standards developed by Kaiser Permanente CMI.
- A continuous monitoring system that evaluates not only HEDIS data but also clinical outcomes, process measures, provider compliance to guidelines, and patient engagement in their own health care decision

- Links to community programs and organizations that can support or expand our system's care for chronically ill patients and prevention strategies

As described in the Asthma Program, a web-based population care management tool known as the Panel Support Tool (PST) and KPHC are essential components of the Regional Diabetes Management Program.

The Regional Diabetes Committee (RDC) sets standards of practice based upon the recommendations made through the CMI National Knowledge base. The RDC provides clinical education, develops tools for the delivery of care, and provides management guidelines. The RDC utilizes a number of management tools, in particular PST.

PSS Staff have been specially trained in the understanding and management of diabetes as a medical condition. They assist the PCP and health care team in reviewing and adjusting medications, ordering regular laboratory and diagnostic tests, providing health-related education, and performing routine check-ups.

The Hawaii Region also has a mechanism that allows the member to assess how well their condition is being managed. One example is the program called HealthMedia®: Care™ for Diabetes available on the member website, kp.members.org. The online program, free to members, is customized specifically by assessing a member's daily routine, general health and providing ways to manage their diabetes more effectively. A member can review his plan online anytime—24 hours a day, seven days a week—or print out a copy to discuss with his physician at the next office visit.

Identifying Eligible Members with Diabetes

All members with Diabetes are eligible for the Diabetic Care Management Program. The PST facilitates the integration of disease management processes into primary care by electronically identifying the relevant chronic condition interventions specific to each member.

Providing Eligible Members with Information

All members are informed about our member web site, www.kp.org, and its special feature Health Topic on Diabetes. KP.org provides members with information about:

- Getting Care (Online provider and facility directory, appointment, nurse advice line, non-urgent medical questions)

- Getting Prescriptions
- Exploring complementary and alternative medicine
- Getting and staying fit (Health Encyclopedia, Health Education materials, Thriving including Healthy Lifestyles and Balance programs)

All members receive the *Partners in Health* member publication three times a year. The publication provides a schedule of available disease management support classes, including diabetes classes, smoking cessation programs, exercise classes and information on how to register and where to attend.

Measuring Effectiveness of our Diabetes Program

Clinical indicators reflecting important elements of care promoted by the Diabetes Program are measured and monitored by the HEDIS Comprehensive Diabetes Care measures. Regional HEDIS reports are compared to other Kaiser Permanente regions, local competitors, and National Quality Compass benchmarks. Reports are disseminated to the Primary Care Team physician and Health Plan Leadership as well as to the Quality Council (QC). The Diabetes Management Program is evaluated on % of: A1C screenings, LDL screenings, retinal exams, A1c > 9, A1c $\geq$ 7, A1c < 7, LDL < 100, and BP <130/80.

C. Quantitative data on health improvement of members in two disease management programs the applicant is currently operating in Hawaii or another state.

Clinical indicators reflecting important elements of care are measured using the HEDIS asthma and diabetes effectiveness of care measures. Regional HEDIS reports are compared to other KP regions, local competitors, and national.

The following are HEDIS asthma and diabetes measures for 2010:

Measure/Data Element	Rate
Use of Appropriate Medications for People With Asthma (asm)	

5-11 Years	98.78%
12-50 Years	94.51%
Total	96.53%

Measure/Data Element	Rate
Comprehensive Diabetes Care (cdc)	
Hemoglobin A1c (HbA1c) Testing	88.31%
HbA1c Poor Control (>9.0%)	51.69%
HbA1c Control (<8.0%)	35.96%
HbA1c Control (<7.0%)	18.41%
Eye Exam (Retinal) Performed	75.96%
LDL-C Screening Performed	85.17%
LDL-C Control (<100 mg/dL)	42.47%
Medical Attention for Nephropathy	84.49%
Blood Pressure Control (<130/80 mm Hg)	51.91%
Blood Pressure Control (<140/90 mm Hg)	76.63%

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Section 80.335

Utilization Management Program and Authorization of Services

(8 pages maximum)

80.335.1 Utilization Management Program (UMP) Narrative

The applicant shall provide a narrative describing its:

A. Utilization Management Program (UMP) including:

1. A description of the committee responsible for the UMP as well as its functions and responsibilities, and how it exercises these responsibilities;

The Resource Stewardship-Utilization Management Committee (HRS-UMC) is a partnership and shared responsibility with Kaiser Foundation Health Plan, Kaiser Foundation Hospital and Hawaii Permanente Medical Group (HPMG). These entities partner to provide and coordinate high quality and effective medical management for Health Plan members while striving continuously to improve the quality, safety and service provided.

The HRS-UMC provides oversight and coordination of utilization management (UM) processes, activities, and performance across the continuum of care at Kaiser Permanente Hawaii (KPHI), including UM in the hospital, clinic, outside services, and behavioral health services. It serves as the review and approval body for utilization/resource management policies, procedures, utilization targets, UM guidelines and criteria, goals and improvement activities. It ensures regulatory compliance with all internal and external regulatory bodies and agencies. It is also responsible for the annual development of utilization targets, goals and establishing regional priorities.

The HRS-UMC is responsible for reviewing and prioritizing the UM opportunities identified by various committees and groups. Projects are established based on the priority or the project in relationship to the organizational mission, goals, strategies, potential for added benefit to Kaiser Permanente customers, and the resources required to complete the project.

The HRS-UMC is co-chaired by the Associate Medical Director of Outside Services and Network Management and the Executive Director and Administrator of Continuing Care and Ancillary Services.

HRS-UMC goals and objectives include:

- To ensure that the Kaiser Permanente Hawaii Utilization Management / Continuing Care programs are aligned with the Program's quality agenda.
- To address utilization issues, monitor utilization performance such as Average Length of Stay (ALOS), Patient Days Rates, Discharge Rates, etc., and follow-up on utilization performance improvement opportunities across the continuum of care.
- To provide linkage with Hawaii Quality Committee (QC) to ensure that quality and utilization goal and activities are aligned in Kaiser Permanente Hawaii.
- To request and review service area utilization management initiatives, action plans and outcomes.
- To sponsor utilization projects and initiatives across the continuum of care that also improves quality of care and clinical outcomes, and ensures the integration of patient safety.
- To review and approve policy decisions related to utilization management.
- To address and ensure compliance with regulatory requirements and accreditation standards related to UM.
- To provide leadership and support for Kaiser Permanente Hawaii as we strive for improved quality and appropriate utilization.

- To ensure the integration of quality, utilization management and finance to better understand the costs and benefits of any utilization initiative, while maintaining or improving the quality of care delivered to Kaiser Permanente members.
- To monitor high-cost and high-volume services/drugs and to have a systematic process to measure, track, and analyze data related to monitoring potential areas of over and under-utilization and to initiate appropriate action.
- To ensure that the needs of the individual member and available hospital and community resources are taken into consideration during all processes related to the medical plan of care and utilization management efforts.
- To analyze and utilize emerging new technology appropriately, effectively, and efficiently.
- To use available medical services within Kaiser Permanente Hawaii to avoid costly outside services and to better coordinate and manage the care of Kaiser Permanente members.
- To promote Member/Provider satisfaction and include Member/Provider feedback for continuous program improvement.

2. A description of how it detects, monitors and evaluates under-utilization, over-utilization and inappropriate utilization of services as well as the processes to address opportunities for improvement;

To provide the most appropriate health care to members and patients, Kaiser Permanente and its practitioners strive to continuously improve the use of resources. The delivery of appropriate care is achieved by optimizing the use of resources in providing high-quality patient care. Inappropriate care occurs when there is over utilization, under and/or inappropriate utilization.

Monitoring for potential areas of over or under and/or inappropriate utilization is one method by which the Hawaii Region monitors the HRS-UMC program. Established thresholds are set to detect and correct potential over and under utilization of services,

including the review of utilization patterns and trends to identify potential areas of inappropriate utilization. Targeted patterns, trends, and indicators are drilled-down and analyzed to identify essential initiatives of opportunities. Interventions are designed to address the potential over or under and/or inappropriate utilization of services, and are measured on performance effectiveness.

The UM program has several mechanisms that monitor utilization performances against approved targets within the Region. It monitors over and under utilization, readmission rates and the consistency of UM decision-making. The UM program conducts annual physician satisfaction surveys to monitor UM processes and continuity of care. It analyzes and reports findings and initiates appropriate improvement actions as needed.

The HRS-UMC reviews and evaluates trends by closely scrutinizing data reports, requesting specific drill downs and identifying opportunities for improvement.

The UM reports include, but are not limited, to Average length of stay in hospital (ALOS), Hospital days/1000 members and discharge rate for the region, Readmissions, Repatriations, ED admit and non-admit rates, SNF days/1000 members, ALOS, Home Health, Palliative and/or Hospice data, Disease Management data, Behavioral Health utilization reports, Pharmacy and other ancillary services utilization, Member and patient satisfaction with UM process, Consumer Assessment of Health Plans Survey (CAHPS), Concerns from Customer Feedback System (CFS) regarding UM issues, and Appeals.

Other ad-hoc data, reports, and analysis may be conducted based on findings and recommendations from quality management, risk management, patient safety, etc.

3. A discussion of strategies to improve health care quality and reduce cost by preventing unnecessary hospital readmissions and by decreasing inappropriate emergency department utilization; and

All new QUEST members are informed of the options to accessing care such as urgent care, after hours care, and the Nurse Advice Line in the member handbook. Additionally, all new adult members on Oahu are contacted by a Case Manager

Associate (CMA) for “new member onboarding”. The goal of the onboarding process is to help new members navigate and access care and services at Kaiser Permanente. The CMA confirms receipt of the new member handbook and provides information on the hours of operation and phone numbers to after hour care, urgent care, and the 24-hour Advice Nurse Line, as well as the kp.org website. On Maui, a pilot program for new QUEST members was recently implemented which is similar to the Oahu onboarding process. New members are contacted soon after enrollment into the health plan and information on options to accessing care is provided. This information is reinforced during a follow-up face-to-face meeting with a QUEST RN case manager.

Other strategies are employed to manage resource utilization in the hospital. Case Managers/Care Coordinators in the Emergency Department (ED) facilitate appropriate admissions as well as coordinate appropriate level of care for the members. Efforts are made to proactively prepare the hospitalized patient and his/her family for post-hospital continuing care needs and plans.

Additionally, these programs/initiatives will be implemented to assist with the reductions of readmissions and inappropriate ED utilization: Heart Failure Transitional Care program, Post-hospital discharge phone calls, Patient Centered Medical Home (including post-hospital PCP appointments within 7-14 days), Case reviews of readmission cases, Inpatient palliative care (IPAL), Palliative Care in the nursing facilities, and Advanced Illness Care Coordination (AICC)

The coordination and integration of all Care Management Programs and linkages with the Outside Utilization and UM across the continuum must continue to be developed with a focus on: appropriate and proactive outpatient clinical management of chronic conditions and frequent utilization; incorporating data from frequent utilization to help future planning for population care management programs; timely and appropriate referrals to other disciplines such as social work, dietary, and pharmacy, etc. to assist in management of the patient; heightened emphasis on coordination of care for members identified with asthma, congestive heart failure (CHF) and diabetes across the

continuum of care (i.e. Patient Centered Medical Home); Palliative and Transitional Care Management.

4. A discussion of any special issues in applying UM guidelines for behavioral health services; and

The Hawaii Region provides Behavioral Health Services (BHS) for Oahu and Maui.. Protocols used by triage staff are reviewed and/or revised every two years. The Physician Chair of BHS leads the group of BHS Physician Advisors for UM. The Physician Advisors for Behavioral Health perform utilization review, providing final medical necessity determinations.

Established policies, procedures, and protocols address the urgency of the patient's clinical circumstances and define the appropriate care setting and treatment resources for behavioral health and substance abuse.

Criteria for behavioral health services are based on clinical evidence and currently accepted industry practice as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Criteria address a full range of services and levels of care including: inpatient, continued inpatient stay, residential or day treatment, and outpatient services. The Behavioral Health criteria are annually reviewed by the Chief of Behavioral Health prior to review and endorsement by the HRS-UMC. All other criteria for Behavioral Health Services are annually reviewed by the appropriate medical department before review and approval by the HRS-UMC.

Criteria used in BHS are InterQual, American Society of Addiction Medicine (ASAM), Global Assessment of Function (GAF), and Diagnostic and Statistical Manual by the American Psychiatric Association (DSM-IV).

Concurrent utilization review for acute, residential, and outpatient behavioral health and chemical dependency services are provided by a licensed clinical social worker.

B. UMP and Authorization of Services – Prior Authorization (PA) including:

1. A description of the PA process, including how PAs will be applied for members requiring out-of-network, including out-of-state, services or services for conditions that threaten the member's life or health;

Health Plan provides most services through its own hospital and clinics; through physicians of HPMG; and to a much lesser extent, through providers contracted through Health Plan's Provider Contracting & Relations Department. The Health Plan has entered into an agreement with HPMG to provide or arrange for physician services for Kaiser Permanente members, including QUEST. Services provided through contracted providers accounts for only 2% of all services provided for Kaiser Permanente members.

When services or items from an outside provider are requested, a prior authorization is generated by the physician and submitted to Kaiser Permanente's Authorization and Referral Management Department (ARM). If the request does not meet department specific pre-established criteria, the request is sent to the Department Chief/Designee. The Chief/Designee evaluates the request, makes a determination, and notifies ARM. ARM ensures all of the following criteria are met before the authorization is complete:

- The service or item is certified as medically necessary by the Chief/Designee
- The service or item is a covered benefit
- The service or item is not available in-Plan
- The patient is an eligible member
- The patient has benefits available
- Referral parameters (frequency/duration) are clearly defined
- Selected provider is credentialed/contracted with Kaiser Permanente Health Plan

If all of the criteria are met, ARM issues the authorization to the requesting provider and informs the member. If criteria are not met, ARM or the ARM Medical Director contacts the referring provider to discuss the case. Authorization or denial will be made and member will be notified within the established timeframes. If denied, the member will be notified in writing with appeal rights within established timeframes.

For services not available in the State or on the island in which the member resides, member will be sent off-island with transportation, meals and lodging for the member, and any needed attendant, arranged and provided for by the Health Plan.

Authorization determinations are made in a timely manner to accommodate the clinical urgency of the situation, and within the timeframes outlined in Section 50.900 of the RFP. Prior authorizations for emergency services, services needed within 2 days, and admissions to designated facilities are not required.

2. **A description of how it will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope; and**

In accordance with the Resource Stewardship Program Description, Regulatory and Accredited Standards, the Utilization Management (UM) Program applies the UM criteria based on individual needs of the member, consideration for patient safety, and assessment of the Hawaii Region delivery system. UM reviews the criteria at least annually, and updates as necessary.

3. **A description of how it will ensure consistent application of review criteria**

Kaiser Permanente Hawaii has defined Utilization Management criteria to ensure utilization decisions are made in a fair and consistent manner. All UM criteria are reviewed and updated on an annual basis. UM Program policies and procedures are

also in place to ensure appropriate professionals are making UM decisions. An overview of the UM criteria is provided during new provider orientation. In addition, there is criteria information in provider manuals. Inter-rater reliability review activities are conducted at least annually to assess the consistency with which physician and non-physician reviewers apply UM criteria.

Physicians with a current unrestricted license make all medical necessity denial determinations. This includes behavioral health and non-behavioral health decisions. HPMG board-certified physicians are also consulted to assist in making medical necessity determinations as needed. Other staff are involved in different steps in the decision making process. Utilization decisions are made timely to accommodate the clinical urgency of the situation using relevant clinical information.

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Section 80.340

Health Plan Administrative Requirements

(18 pages maximum)

80.340.1 Health Plan Administrative Requirements Narrative -Fraud and Abuse

The applicant shall:

A. Provide a comprehensive description of how it shall detect, investigate, and communicate fraud and abuse to DHS as described in Section 51.300; and

The Compliance Program is structured to encourage collaborative participation among the Kaiser Permanente Hawaii corporate and organizational structure and its various affiliates. The Compliance Program focuses on the prevention, detection, and correction of identified violations of federal and state laws and regulations, as well as unethical conduct, and fosters an environment that encourages Kaiser Permanente-Hawaii employees to report concerns about business practices without fear of retaliation.

The Kaiser Permanente Hawaii's Compliance Plan document is a written narrative that outlines the compliance strategies and efforts set forth by the organization to create an environment that encourages compliance with policy and procedure, as well as all applicable federal and state standards, rules and regulations. The Plan document will be updated to include all changes implemented with respect to addressing Medicaid Fraud & Abuse requirements.

The Kaiser Permanente Hawaii Anti-Fraud Plan outlines the philosophies, accountabilities, policies and standards, and anti-fraud activities performed by the organization in the Hawaii Region. Many of the activities detailed in the Anti-Fraud Plan address requirements of Med-QUEST. Kaiser Permanente Hawaii Anti-Fraud Plan directs the organization to work

cooperatively with law enforcement and regulatory agencies to prevent fraudulent activity and report fraudulent activity, as appropriate. The Plan provides guidance for reporting within 30 days of discovery any instances in which fraud is suspected to the Med-QUEST Division. The National Special Investigations Unit members are experienced in interfacing with law enforcement and referring cases when criminal fraud matters surface.

B. Continually improve and modify their fraud and abuse detection processes.

Training and education of all Kaiser Permanente-Hawaii personnel on the ethical and compliant behaviors expected of them is a key component of the Compliance Program. Kaiser Permanente-Hawaii provides its employees with the training and education needed to perform their job in a legal, ethical and appropriate manner. Kaiser Permanente's annual compliance training includes valuable information on preventing, detecting, and correcting fraud, waste, and abuse – including how and when to use the Compliance Hotline. Annual training on fraud, waste, and abuse is now a condition of employment at Kaiser Permanente.

- Principles of Responsibility Training is mandatory for all employees that work over 160 hours per year at a Kaiser Permanente facility.
- General Training is a requirement of the Corporate Integrity Agreement (CIA) and at a minimum shall explain the CIA requirements and Kaiser Permanente Hawaii's Compliance Program.
- Specific Training is a requirement of the CIA and discusses billing, coding, documentation and reimbursement topics with respect to federal health care programs. Also included are examples of proper and improper claim submissions.

Policies and procedures for Fraud, Waste and Abuse are reviewed annually. Necessary revisions, based on new rules or events, will be made to ensure the policies are up to date.

1. Education about fraud and abuse identification and reporting in provider and member materials;

- Work plan efforts in this area are in the planning and development stages. The National Compliance Office, Communications Director will be working to enhance and create fraud control communications for providers and members in all regions.
- The Hawaii Region will use the nationally developed communication in both the member materials and the provider manuals.
- Communication will be developed that provides information to the members and network providers regarding the State's Hotline for Fraud & Abuse issues.

2. Effective lines of communication between the compliance officer and the organization's employees;

Every employee is required to act ethically, with integrity, and report illegal, fraudulent, dishonest, or unethical behavior they are aware of within the Kaiser Permanente-Hawaii organization. In addition, each employee who reports suspected violations should know they are protected from retaliation. Employees are required to report suspected violations in one of the following ways:

- Reporting to a Supervisor/Manager – Personnel are always encouraged to speak with their direct supervisor about instances of suspected illegal, improper, or unethical behavior they have witnessed.
- Reporting to the Regional Compliance Officer - The Regional Compliance Officer is accessible to all Kaiser Permanente-Hawaii personnel who may wish to report their concerns directly. Reports directly to the Regional Compliance Officer or Director of Regional Compliance, or one of the Compliance Staff are handled with the utmost confidentiality.
- 24-hour Confidential Compliance Line, KP Compliance Connection – A 24-hour confidential, national disclosure line is available to all personnel who wish to report compliance and ethics concerns. The Kaiser Permanente Compliance Connection provides a safe responsive, independent, and anonymous method to report possible wrongdoing, without fear of retaliation. The line enables the organization to identify and promptly address unethical, illegal, or questionable behavior in the workplace.

The line is a toll free number that is available 24 hours a day, seven days a week. The National Compliance Office has contracted with an independent company to take the caller's detailed report. The information is then sent to the National Compliance Office to review concerns.

3. **Enforcement of standards through well-publicized guidelines; Kaiser Permanente shall promote awareness of issues relating to fraud, waste, and abuse through well publicized disciplinary guidelines for employees.**

- Discipline Policy for Compliance Related Issues – Kaiser Permanente Hawaii maintains disciplinary policies for Hawaii Permanente Medical Group (HPMG), Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Foundation Hospitals (KFH). Current disciplinary policies will be reviewed and updated, as appropriate, to include addressing instances of fraud & abuse by an employee.
    - HPMG Discipline Policy for Compliance Related issues – this policy applies to all employees of HPMG. It defines the expectation of all employees and the existence of a disciplinary structure when non-compliant activities occur.
    - House Rules and Disciplinary Action Guidelines for Violations – this policy applies to all employees of KFHP and KFH. It defines the expectations of all employees and the existence of a disciplinary structure when non-compliant activities occur.
- Disciplinary Standards for Compliance Training – All Kaiser Permanente Hawaii's employees shall receive the Principles of Responsibility (POR), and compliance training within thirty (30) days of hire or interdepartmental transfer and annually thereafter. To ensure that Kaiser Permanente (KP) Hawaii Region employees receive appropriate training regarding the Principles of Responsibility and compliance, completion of this mandatory training is a conditional requirement of working at Kaiser Permanente Hawaii.
- Background Screening of Job Applicants – Kaiser Permanente Hawaii performs extensive background screening on all candidates who accept conditional offers of employment. The screening must be successfully completed and the candidate cleared before hire.

- Screening of External Contractors – In support of efforts to ensure that contractors, their employees, or subcontractors are eligible to participate in Federal health care programs, Kaiser Permanente-Hawaii is in the process of amending contract language for all current contracts to include language to that effect, and is including similar language in all future contracts between an external individual or entity. This language will reflect the prohibition of maintaining or entering into a business relationship with any individual or entity that has been deemed ineligible for participation in Federal health care programs. For current contractors, contracts are in the process of being amended to include the provision requiring screening for eligibility for participation in Federal health care programs. All current contractors are reviewed for ineligibility and will be screened annually.

- Identifying Ineligible Individuals – Kaiser Permanente-Hawaii prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs. Therefore, at least annually, Kaiser Permanente Hawaii Region shall screen all Screened Persons against the Office of Inspector General (OIG), General Services Administration (GSA), Office of Personnel Management (OPM) and Opt-out lists to ensure that they are not ineligible individuals or entities.

- Conflict of Interest Policy – Kaiser Permanente participates in the NCO practice of annual distribution of a Conflict of Interest Questionnaire. The Questionnaire is used for self-reporting or by management, as appropriate. This Questionnaire is distributed to key individuals, including those individuals in positions that, relative to others in the organization, have the most potential to impact on the organization's interests.

80.340.2 Health Plan Administrative Requirements Attachment and Narrative - Organization Charts (Attachment) and Narrative on Organization Charts

The applicant shall provide organization chart(s) and a brief narrative explaining its organizational structure, including: (1) whether it intends to use subcontractors for activities and functions and, if so, how it will manage and monitor them; and (2) how it will ensure coordination and collaboration among staff located in the State of Hawaii and

those in the Continental United States.

Kaiser Foundation Health Plan, Inc. (KFHP) Hawaii is a mixed model Health Maintenance Organization. KFHP contracts with Kaiser Foundation Hospitals (KFH) for inpatient services and the Hawaii Permanente Medical Group (HPMG) for professional services. We are collaboratively co-managed by KFHP (generally considered the insurer), KFH (generally considered the care facilities), and HPMG (generally considered the caregivers). HPMG delivers medical care in an exclusive provider relationship in mutual collaboration with the KFHP and KFH

Kaiser Permanente Hawaii does not, nor intends to, subcontract any activities or functions related to this contract.

All Kaiser Permanente Hawaii Region staff is located in the State of Hawaii.

See attached Organization Chart for Kaiser Permanente Hawaii Region's Regional Executive Team.

80.340.3 Health Plan Administrative Requirements Narrative Organization and Staffing Table

In a table format, the applicant shall describe its current or proposed staffing that includes the number of full-time equivalents (FTEs) for all positions described in the table in Section 51.410. Adequacy of proposed staff shall be judged based on an enrollment of approximately 20,000 members.

Positions	Current FTEs (all located in Hawaii)	Lines of Business
Administrator/CEO/COO/Executive Director	1	QUEST only
Medical Director	0.5	QUEST only

Financial Officer	1	All
Quality Management Coordinator	1	All
Behavioral Health Coordinator	1	All
Pharmacy Coordinator/Director/Manager	1	All
Prior Authorization/Utilization Management/Medical Management Director	1	All
Prior Authorization/Utilization Management/Medical Management Staff	26	All
EPSDT Coordinator	0.5	QUEST only
Member Services Director	1	QUEST only
Member Services' staff (to include call center staff)	1	QUEST only
Provider Services/Contract Manager	1	All
Provider Services/Contract staff	5	All
Claims Administrator/Manager	1	All
Claims Processing Staff	9.5	All
Encounter processors	1	QUEST only
Grievance Coordinator	1	All
Credentialing Program Coordinator	1	All
Catastrophic Claims Coordinator *	0.1	QUEST only
Compliance Officer	1	All
Information Technology (IT) Director or Chief Information Officer (CIO)	1	All
IT Hawaii Manager	1	All
IT Staff	120	All

80.340.4 Health Plan Administrative Requirements Narrative Reporting Requirements

The applicant shall describe its internal systems or processes to:

A. Gather data to meet reporting requirements;

The calendar of reports due is reviewed at the beginning of each month and reminder emails regarding upcoming due dates are sent to content experts for each of the functional

areas responsible for the specific report. Report data is extracted from the Kaiser Permanente source systems, which include data on membership, care provided by Kaiser Permanente providers, care provided by non Kaiser Permanente providers, and all drugs dispensed at Kaiser Permanente pharmacies.

B. Compile and review data for consistency and accuracy prior to submitting to DHS;

Data passes through eligibility and other edits, and is reformatted into the applicable QUEST report file formats. Source information for the data is retained to allow for periodic validation sampling. Source system extracts are monitored and reviewed by the business analyst. Data sources are also interrogated if previous reports show significant differences in the information reported.

C. Submit reports to DHS in a timely manner; and

The Government Programs department emails a reminder to each functional area prior to report due dates. A status check with the content expert is performed by phone, email, or in person for all reports not received by the department's internal deadline. All reports are submitted to Med-QUEST by the due date. However, when needed for significant and unexpected delays, we will request an extension to the due date from Med-QUEST. All extension due dates will be met.

D. Develop corrective action plans (CAP), as needed, to improve health plan processes.

Corrective action plans are be developed and implemented as needed. Often reports and findings will indicate the deficiency as well as the due date to respond. If no due date is indicated, the CAP response will be submitted to the reviewer no later than 30 days from receipt of the report findings.

All findings are reported to the Government Programs Manager to evaluate potential issues that may require changes in processes.

80.340.5 Health Plan Administrative Requirements Narrative – Encounter Data Reporting Requirements

A. The applicant shall describe how it will ensure that all encounter data requirements are met and that encounter data is submitted to the State in a timely and accurate manner as described in Section 51.580. As part of this description, please provide a narrative of how you prepare encounter data reports and how you assure accuracy.

The Kaiser Permanente QUEST Program encounter data is extracted and submitted to the State of Hawaii on a monthly basis, in accordance with the requirements and specifications in the Health Plan Manual provided by the State. Encounters are certified and submitted by Kaiser Permanente as required in 42 CFR 438.606 and as specified in Section 51.620 of the RFP.

Data extracts from 3 source systems provide the data to the QUEST application in order to generate the encounter file submitted to MQD. The 3 source systems are Kaiser Permanente HealthConnect® (KPHC), Kaiser Permanente Pharmacy system, and Kaiser Permanente Outside Purchases system (KPOPS). The KPHC transactions comprise of inpatient and outpatient encounters where care is provided by Kaiser Permanente providers. Kaiser Permanente Pharmacy system transactions comprise of transactions associated with all drugs dispensed at Kaiser Permanente Pharmacies. The KPOPS transactions comprise of all encounters where care is provided by non-Kaiser providers. Prior to extraction, the data is processed through edits and queues internal to each of the source systems to ensure accuracy and completeness.

The extracts are processed on a monthly basis, at the earliest on the 16th calendar day, and at the latest, the 21st calendar day. The data is processed through eligibility and other edits and is reformatted into the proprietary QUEST encounter file format. The file is submitted to

MQD via their secured ftp portal (https://sftp.statemedicaid.us/) by the first Tuesday of the month, and at the latest on the first Wednesday of the month.

Additionally, the timeliness, accuracy and completeness of the encounter data are tracked at two checkpoints;

1. The source system extracts are monitored and reviewed by the Encounter Data Analyst.
2. The Kaiser Permanente QUEST encounter system is monitored and review by the Encounter Data Analyst.

Tracking reports are compiled and submitted to the Government Reimbursement and Government Programs departments.

B. Please provide a narrative on what trend analysis you perform on your encounter data.

Reasonableness and integrity tests on the encounter data are performed prior to submission to ensure accuracy of the data. Errors are identified prior to submission from the source system extracts and from the Kaiser Permanente QUEST encounter system. The error correction process involves the appropriate department (i.e., Patient Financial Services, Community Medical Service, Government Programs, Government Reimbursement, etc.).

Additionally, the Encounter Data Analyst will track, analyze and trend the encounter data submitted on a quarterly basis. The elements to include in the trending reports will be determined and reviewed by the clinical and financial departmental stakeholders.

80.340.6 Health Plan Administrative Requirements Narrative-Information Technology

The applicant shall provide:

A. A description of its information systems environment including:

1. Details on the systems that will be used to perform the key functions ("key production systems") noted in Sections 51.220, 51.300, 51.580, 60.110 and 60.310. At a minimum include:

- System name and version;

- Number of users;

- Who maintains the system and from what location;

- The location of the data center where the system is housed;

- Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date);

- Its ability to receive different rate codes and contract types; and

- Major system functionality.

a. System name and version – EpicCare Summer 09
b. Number of users – 5000+
c. Who maintains the system and from what location – National and Hawaii Epic Teams located in various Kaiser regional offices.
d. The location of the data center where the system is housed – Corona, California
e. Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date) – Currently in use
f. Its ability to receive different rate codes and contract types – No, but interfaces with Membership System
g. Major system functionality – Electronic Health Record of services

a. System name and version – Quest Encounter mainframe system
b. Number of users – 30
c. Who maintains the system and from what location – Hawaii Regional Application Delivery, Hawaii IT
d. The location of the data center where the system is housed – Corona, California

e. Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date) – Currently in use
f. Its ability to receive different rate codes and contract types – No
g. Major system functionality - Encounter Data Reporting

a. System name and version – Quest Membership mainframe system
b. Number of users – 30
c. Who maintains the system and from what location – Hawaii Regional Application Delivery, Hawaii IT
d. The location of the data center where the system is housed – Corona, California
e. Whether the system is currently in use or being implemented (if the system is being implemented, please indicate the expected go-live date) – Currently in use
f. Its ability to receive different rate codes and contract types – Able to receive different rate codes and contract types
g. Major system functionality - Daily Rosters/Health Plan Reimbursement

2. How these key production systems are designed to interoperate: (a) how identical or closely related data elements in different systems are named, formatted and maintained; (b) data element update/refresh methods and frequency/periodicity; and (c) how data is exchanged between key production systems (i.e. how these systems are "interfaced" to facilitate work processes within your organization).

834 files are received from the MQD sftp site on a daily and monthly basis and processed the same day that the file is received. Data from the input files are transmitted to Kaiser's EDI group and translated to match the format in the QUEST Membership system.

3. How these systems can be accessed by health plan users (for instance, can field-based case managers access case management information via portable devices such as laptops) to facilitate work, promote efficiencies and deliver services at the

point of care, including how it will make available to providers electronic prior authorizations.

Health Plan users are able to use Kaiser Permanente issued laptops to connect via VPN to the Kaiser network. Once logged on to the Kaiser network, users are able to access authorized applications in order to access the mainframe system (QUEST Membership) and KP HealthConnect® system (EpicCare Summer 09).

4. **An explanation of how it will ensure that its systems can interface with the DHS systems and how it will institute processes to insure the validity and completeness of the data submitted to the DHS.**

Kaiser Permanente will continue to exchange information with DHS using secured file transfer protocol (sFTP). Every day and once a month our business users log in to the DHS secured ftp server and extract membership enrollment information. Every month the payment information is extracted. In a like manner we use secured ftp when we send information back to Med-QUEST such as encounters, providers, and acknowledgements. Our system validates the control count from each file that is received or sent between the two parties to ensure the completeness of the data.

As part of its response, the applicant shall support the narrative with diagrams that illustrate: (a) point-to-point interfaces; (b) information flows; (c) internal controls; and (d) the networking arrangement (AKA "network diagram") associated with the information systems profiled. These diagrams shall provide insight into how its systems will be organized and how they will interact with DHS systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with this contract.

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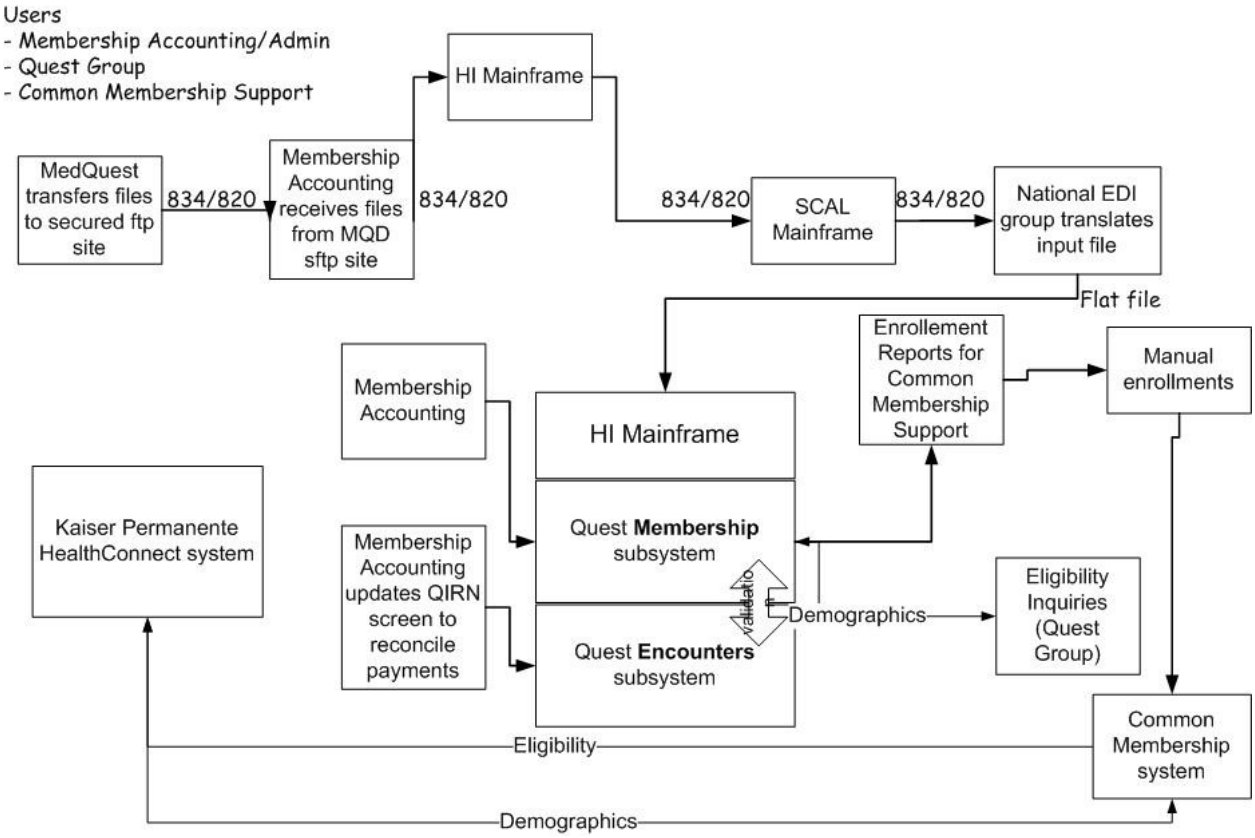
QUEST COMPONENT FLOW FOR 834s & 820s – **DAILY PROCESS**



B. A description of how it shall ensure confidentiality of member information in accordance with professional ethics, state and federal laws, including HIPAA compliance provisions; and

Kaiser Permanente Hawaii has a Compliance Officer and, reporting to her, a Privacy Officer, who with their staff work to ensure compliance with laws and regulations at all levels. The Health Insurance Portability & Accountability Act (HIPAA) and other federal and state laws are included in the scope of their concerns. Kaiser Permanente maintains a national, toll-free Compliance Hotline which employees and physicians may use to report any compliance concerns which they feel unable to share with their own supervisors or managers. All Kaiser Permanente physicians and employees are trained in principles of responsibility. At Kaiser Permanente, compliance is everyone's responsibility. Kaiser Permanente will continue to

use secured ftp to exchange data with the Med-QUEST Division of the State of Hawaii as described above in order to maintain confidentiality of member information when exchanging information with DHS.

C. A description of its disaster planning and recovery operations policies and procedures both for operations and for member care.

All mainframe, mid-range, and distributed/open systems production applications, operating systems, databases, and software tools, including all documentation essential to their recovery, must be backed up and stored offsite in an environmentally controlled storage facility. If this is deemed not practical or justified from a business or technical perspective, then a waiver process is followed. All of this is described in Kaiser Permanente's "Disaster Recovery Back Up and Recovery Standard Operating Procedure (SOP)". Additionally, the health plan will provide the DHS with a copy of its documentation describing its disaster planning and recovery operations within thirty (30) days of contract award as required in RFP Section 51.270.

See attached Disaster Recovery Back Up and Recovery Standard Operating Procedure

80.340.7 Financial Responsibilities Narrative -Third Party Liability

The applicant shall describe how it will coordinate health care benefits with other coverages, its methods for obtaining reimbursement from other liable third parties, and how it will fulfill all requirements as detailed in Section 60.400.

Kaiser Permanente's Patient Billing Services coordinates health care benefits with other coverage, both public and private, which are or may be available to pay medical expenses on behalf of a member. Reimbursement from all other liable third parties is sought to the limit of legal liability for the services rendered.

At the point of service, a Consent and Conditions Of Payment and Treatment (CCOTP) or a Consent and Conditions Of Admission and Treatment (CCOAT) form is completed. Insurance coverage is verified with the insurance company. If the insurance is valid, the commercial insurance company is considered as primary payer, with Kaiser Permanente QUEST as secondary payer. Billing is done according to priority of insurance carrier.

For non-participating insurance carriers (i.e.: HMSA, HMAA), a patient statement is generated for services since payment will be remitted to the patient rather than Kaiser Permanente. For participating insurance carriers (i.e.: Tricare), payment is sent directly to Kaiser Permanente.

All third party payments collected, including cost avoidance, are retained by Kaiser Permanente. Pay and chase provisions described in 42 CFR 433.139(b)(3)(i)(ii) are followed.

A report of QUEST members with commercial insurance through Kaiser Permanente will be generated and reported to DHS on a quarterly basis.

Additionally, Kaiser Permanente will:

- Continue cost avoidance of the health insurance plans accident and workers' compensation benefits;
- Report all accident cases incurring medical and medically related dental expenses in excess of five-hundred dollars ($500) to the DHS;
- Provide a list of medical and medically related dental expenses, in the format requested by the DHS, for recovery purposes. "RUSH" requests shall be reported within three (3) business days of receipt and "ROUTINE" request within seven (7) business days of receipt. Listings shall also include claims received but not processed for payments or rejected.;
- Provide copies of claim forms with similar response time as the above;
- Provide listings of medical and medically related dental expenses (including adjustments, e.g., payment corrects, refunds, etc.) according to the payment period or "as of" date. Adjustments shall be recorded in the date of adjustment and not on the date of service.;
- Inform the DHS of TPL information uncovered during the course of normal business operations;

- Provide the DHS with monthly reports of the total cost avoidance and amounts collected from TPLs within thirty (30) days of the end of the month;
- Develop procedures for determining when to pursue TPL recovery; and
- Provide health care services for members receiving motor vehicle insurance liability coverage at no cost through the Hawaii Joint Underwriting Plan (HJUP) in accordance with Section 431:10C-401 et. seq., HRS.

Kaiser Permanente Hawaii Region Regional Executive Team

Health Plan, Medical Group and Care Delivery (Hospital and Clinics)

Janet Liang
Regional President
Health Plan/Hospital

Geoff Sewell, MD
HPMG President &
Executive Medical Director

Liza Villanueva
Continuing Care & Ancillary Administrator

Sharon Thomson
VP, Public Relations, Communications & Brand Management

Suzanne Jester
Interim VP, Marketing, Sales & Business Development

Joan Danieley
VP, Health Plan Service & Administration

Susan Murray
VP, Quality, Safety & Service

Thomas Risse
CFO & VP, Business Operations

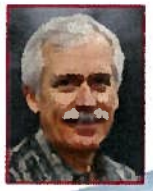
Ben Tamura, MD
AMD, Primary Care & PIC Clinics

Daryl Kuruzawa, MD
AMD, Neighbor Islands

Mark Santi, MD
AMD, Surgical Specialties

Tarquin Collis, MD
AMD, Medical Specialties

Kelley Yim, MD
AMD, Hospital Specialties



Bill Haug
Hospital Administrator

Jason Hall
VP & Chief Administrative Officer

Brian Yoshii
VP, Strategic Support Services

Winona White
VP, Human Resources

Frank Richardson
VP & Regional Counsel, Legal & Government Relations

Stacey Honda, MD
AMD, Ancillary Specialties

James Griffith, MD
AMD, Quality & Professional Chief of Staff

Leighton Hasegawa
Clinical Operations & Finance Administrator

Mike Caps, MD
AMD, Outside Services & Network Management

Karl Pregitzer, MD
AMD, Physician Business Services

Grant Okawa, MD
AMD, Knowledge Management

David D. Bell, MD
AMD, Professional Development & Service

George Apter, HPMG
General Counsel

Red outline = Reports to Janet Liang, Kaiser Permanente Health Plan/Hospital
Blue outline= Reports to Geoff Sewell, MD, Hawaii Permanente Medical Group
VP=Vice-President
AMD=Associate Medical Director

*For descriptions of individual accountabilities, refer to separate organizational charts. Updated 03 29 2011

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