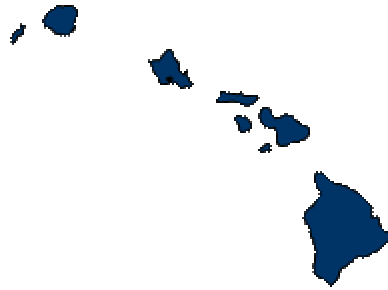
State of Hawaii



Department of Human Services

Med-QUEST Division

2013 Hawaii Provider Survey Report

October 2013

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

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. **Executive Summary 1-1**
   - Introduction 1-1
   - Current Status of Health Care in Hawaii 1-2
   - Summary of Results 1-3
   - Recommendations 1-7
2. **Survey Administration 2-1**
   - Survey Administration and Response Rates 2-1
   - Provider Demographics 2-2
3. **Results 3-1**
   - Provider Survey Analysis 3-2
   - Findings 3-3
4. **Recommendations 4-1**
   - Quality Improvement Recommendations 4-1
   - Future Survey Administration Recommendations for the MQD 4-2
5. **Reader's Guide 5-1**
   - Survey Administration 5-1
   - How to Read the Satisfaction Bar Graphs 5-2
   - Methodology 5-3
   - Limitations and Cautions 5-6
6. **Survey Instrument 6-1**
7. **CD Contents 7-1**
   - CD Contents 7-1

***Appendix A.* Provider Comments A-1**

1. Executive Summary

Introduction

In calendar year (CY) 2013, the State of Hawaii, Department of Human Services, Med-QUEST Division (the MQD) required the administration of surveys to health care providers who serve QUEST and QUEST Expanded Access (QExA) members through one or more QUEST or QExA health plan. The MQD contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Hawaii Provider Survey. The goal of the Provider Survey is to supply feedback to the MQD as it relates to providers' perceptions of the QUEST and QExA health plans (listed in Table 1-1).

Table 1-1—QUEST and QExA Health Plans	
Plan Name	**Plan Abbreviation**
AlohaCare – QUEST	AlohaCare
Hawaii Medical Service Association – QUEST	HMSA
Kaiser Permanente Hawaii – QUEST	Kaiser
'Ohana Health Plan – QUEST and QExA	'Ohana
UnitedHealthcare Community Plan – QUEST and QExA	UHC CP

HSAG and the MQD developed a survey instrument designed to acquire meaningful provider information and gain providers' insight as it relates to the health plans' performance and potential areas of performance improvement. The survey covered topics for primary care and behavioral health providers, including impact of the plans' prior authorization and referral processes on the providers' abilities to provide quality care, satisfaction with reimbursement, and adequacy of the formulary. A total of 1,500 providers were randomly sampled for inclusion in the survey administration: 400 Kaiser providers and 1,100 non-Kaiser providers (i.e., AlohaCare, HMSA, 'Ohana, and/or UHC CP providers). Providers completed the surveys from April to June 2013.

Current Status of Health Care in Hawaii

HSAG recognizes the current issues regarding the state of health care in Hawaii. The provider responses in the survey are impacted by these health care issues. Reports indicate that Hawaii is moving forward with phasing in its electronic medical record capabilities, through the state's version of the Health Information Exchange.[1-1] Numerous physicians, hospitals, and other health care providers have attended training and have begun using the exchange system to share health information electronically.[1-2] This new communication and coordination tool has great potential to assist providers in their care of patients across care networks and may have a positive impact over time on providers' perceptions of administrative burden.[1-3] Continued issues with the current public health care system are driving some providers to restrict or discontinue certain services, leaving patients with fewer choices and delays in obtaining care. In many cases, this leads to patients using the emergency department or urgent care for primary care services.[1-4] This resonates with the latest findings from the Hawaii Physician Workforce Assessment Project that provider shortage continues to be an issue in the state. According to these estimates, Hawaii currently has approximately 700 fewer physicians than it needs, and this deficit will continue to increase given the increased demand for health care. The shortage affects all islands and extends across nearly every specialty area.[1-5]

[1-1] Associated Press. *Hawaii health information network first phase begins*. Star Advertiser, April 6, 2012. Available at: http://www.staradvertiser.com/news/breaking/146425315.html?id=146425315. Accessed on: September 13, 2013.

[1-2] *Hawaii doctors learn new ways technology can help improve patients' lives.* Hawaii News Now, June 23, 2012. Available at: http://www.hawaiinewsnow.com/story/18865014/hawaii-doctors-learn-new-ways-technology-can-help-improve-patients-lives. Accessed on: September 13, 2013.

[1-3] Consillio K. *Castle, Hawaii Pacific Health join data-sharing network*. Star Advertiser, September 3, 2013. Available at: http://www.hawaiihealthcareproject.org/images/pdf/print-media/Castle_Hawaii_Pacific_Health_join_data_sharing_network.pdf. Accessed on: September 13, 2013.

[1-4] Thompson D. *How to Fix Hawaii's Doctor Shortage*. Honolulu Magazine, June 2013. Available at: http://www.honolulumagazine.com/Honolulu-Magazine/June-2013/Fixing-Hawaiis-Doctor-Shortage/. Accessed on: September 13, 2013.

[1-5] Withy K. *Report to the 2013 Hawai'i State Legislature: Findings from the Hawai'i Physician Workforce Assessment Project*. University of Hawai'i. December 2012. Available at: http://www.ahec.hawaii.edu/2013_physicians-workforce_report.pdf. Accessed on: September 13, 2013.

Summary of Results

Where applicable, HSAG conducted tests of statistical significance to determine if significant differences in performance existed between the health plans. Table 1-1 presents a summary of these results.[1-6]

Table 1-1—Plan Comparisons					
	AlohaCare	HMSA	Kaiser	‘Ohana	UHC CP
General Positions[1-7]					
Compensation Satisfaction	▼	▲	▲	▼	▼
Timeliness of Claims Payments	—	▲	—	▼	▼
Providing Quality Care					
Prior Authorization Process	—	—	▲	—	—
Referral Process	—	—	▲	—	—
Formulary	—	—	▲	—	—
Health Plan Communication					
Knowledge	—	▲	▲	▼	▼
Formulary					
Adequate Formulary	—	—	▲	▼	▼
Adequate Access to Non-Formulary Drugs	—	—	▲	▼	▼
Case Management					
Adequate Access to Case Management Services	—	—	▲	▼	▼
Specialists					
Adequacy of Specialists	—	—	▲	—	—
Referral Policy	—	—	▲	—	—
Adequacy of Behavioral Health Specialists	—	—	▲	—	—
Behavioral Health					
Integration of Care and Treatment	—	▲	—	—	—
Communication Policy	—	—	—	—	—

▲ *indicates the plan’s performance is significantly higher than the aggregate performance of the other plans*
— *indicates the plan’s performance is not significantly different than the aggregate performance of the other plans*
▼ *indicates the plan’s performance is significantly lower than the aggregate performance of the other plans*

[1-6] Due to the small number of total respondents for Kaiser, extreme caution should be exercised when interpreting the plan’s results.
[1-7] For purposes of the Compensation Satisfaction and Timeliness of Claims Payments plan comparisons, the plans’ results were compared to the aggregate performance of the other Medicaid health plans and contracted commercial managed care health plans.

The following is a summary of the health plans' performance on the 14 measures evaluated for statistical differences:

- AlohaCare's performance was significantly lower than the aggregate performance of the other plans on one measure.
- HMSA's performance was significantly higher than the aggregate performance of the other plans on four measures.
- Kaiser's performance was significantly higher than the aggregate performance of the other plans on 11 measures.
- 'Ohana's performance was significantly lower than the aggregate performance of the other plans on six measures.
- UHC CP's performance was significantly lower than the aggregate performance of the other plans on six measures.

In order to evaluate trends in provider satisfaction, HSAG compared each health plan's 2013 Provider Survey results to its corresponding 2011 Provider Survey results, where applicable.[1-8,1-9,1-10] Table 1-2 provides the highlights of the statistically significant results from this analysis.

Table 1-2—Trend Analysis

	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
General Positions					
Compensation Satisfaction	⇔	⇔	⇔	⇔	↑
Timeliness of Claims Payments	↑	⇔	⇔	⇔	⇔
Providing Quality Care					
Prior Authorization Process	⇔	⇔	⇔	⇔	⇔
Referral Process	⇔	⇔	⇔	⇔	⇔
Formulary	⇔	⇔	↓	⇔	⇔
Health Plan Communication					
Knowledge	⇔	⇔	⇔	⇔	⇔
Formulary					
Adequate Formulary	⇔	⇔	⇔	⇔	⇔
Adequate Access to Non-Formulary Drugs	⇔	⇔	⇔	⇔	⇔
Case Management					
Adequate Access to Case Management Services					
Specialists					
Adequacy of Specialists					
Referral Policy					
Adequacy of Behavioral Health Specialists					
Behavioral Health					
Integration of Care and Treatment					
Communication Policy					

↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
⇔ *indicates the 2013 top-box rate is not significantly different than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

[1-8] The Provider Survey was not administered in 2012.
[1-9] It should be noted that a trend analysis could not be performed for the Adequate Access to Case Management Services, Integration of Care and Treatment, and Communication Policy measures, since they are new measures for 2013.
[1-10] Given modifications made to the survey instrument, a trend analysis could not be performed for the Adequacy of Specialists, Referral Policy, and Adequacy of Behavioral Health Specialists measures in 2013.

Comparison of the plans' 2013 top-box rates to their corresponding 2011 top-box rates on the eight measures evaluated for statistically significant differences revealed the following summary results:

- AlohaCare scored significantly higher in 2013 than in 2011 on one measure, Timeliness of Claims Payments.
- HMSA did not score significantly higher or lower in 2013 than in 2011 on any of the measures.
- Kaiser scored significantly lower in 2013 than in 2011 on one measure, Providing Quality Care: Formulary.
- 'Ohana did not score significantly higher or lower in 2013 than in 2011 on any of the measures.
- UHC CP scored significantly higher in 2013 than in 2011 on one measure, Compensation Satisfaction.

More detailed discussion of the results can be found in the Results Section beginning on page 3-1.

Recommendations

The Provider Survey revealed that there is an opportunity to improve provider satisfaction. HSAG has detailed some quality improvement (QI) suggestions that may potentially improve provider satisfaction with the domains evaluated.

HSAG also has included recommendations for the MQD aimed at increasing the provider response rates to the survey. HSAG recommends the continued administration of the Provider Survey every two years. Re-measuring the provider survey domains every two years will continue to provide trending information to the MQD, health plans, and providers. HSAG also recommends that the MQD continue to oversample in order to increase the number of providers that participate in the survey.

More detailed discussion of recommendations can be found in the Recommendations Section beginning on page 4-1.

Survey Administration and Response Rates

Survey Administration

The survey administration process consisted of mailing a survey questionnaire, cover letter, and business reply envelope to a random sample of 1,500 providers (400 Kaiser providers and 1,100 non-Kaiser providers). Approximately four weeks after the first survey was mailed to providers, a second copy of the survey questionnaire was mailed to non-respondents.

Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the Web-based survey by logging on to the survey Web site with a designated provider-specific login. Additional information on the survey protocol is included in the Reader's Guide Section of this report beginning on page 5-1.

Response Rates

The response rate is the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire random sample minus ineligible surveys, which included any providers that could not be surveyed due to incorrect or incomplete contact information or had no current contracts with any of the health plans. A total of 184 Hawaii providers completed the survey, including 24 providers from the Kaiser sample and 160 providers from the non-Kaiser sample. Table 2-1 depicts the sample distribution of surveys and response rates.

Table 2-1—Provider Sample Distribution and Response Rate

Sample	Sample Size	Ineligible Surveys	Eligible Sample	Total Respondents	Response Rate
Kaiser	400	61	339	24	7.1%
Non-Kaiser	1,100	104	996	160	16.1%
Hawaii Provider Total	**1,500**	**165**	**1,335**	**184**	**13.8%**

HSAG and the MQD had hoped to achieve a response rate of 20.0 percent for the survey; however, the overall response rate of 13.8 percent falls below the normal range of provider survey response rates that HSAG has observed in other states. The response rate for the Kaiser sample was considerably lower than the non-Kaiser sample (7.1 percent and 16.1 percent, respectively).

Due to the low response rates, caution should be exercised when interpreting the health plans' results given the increased potential for non-response bias and likelihood that provider responses are not reflective of all providers serving Med-QUEST members.

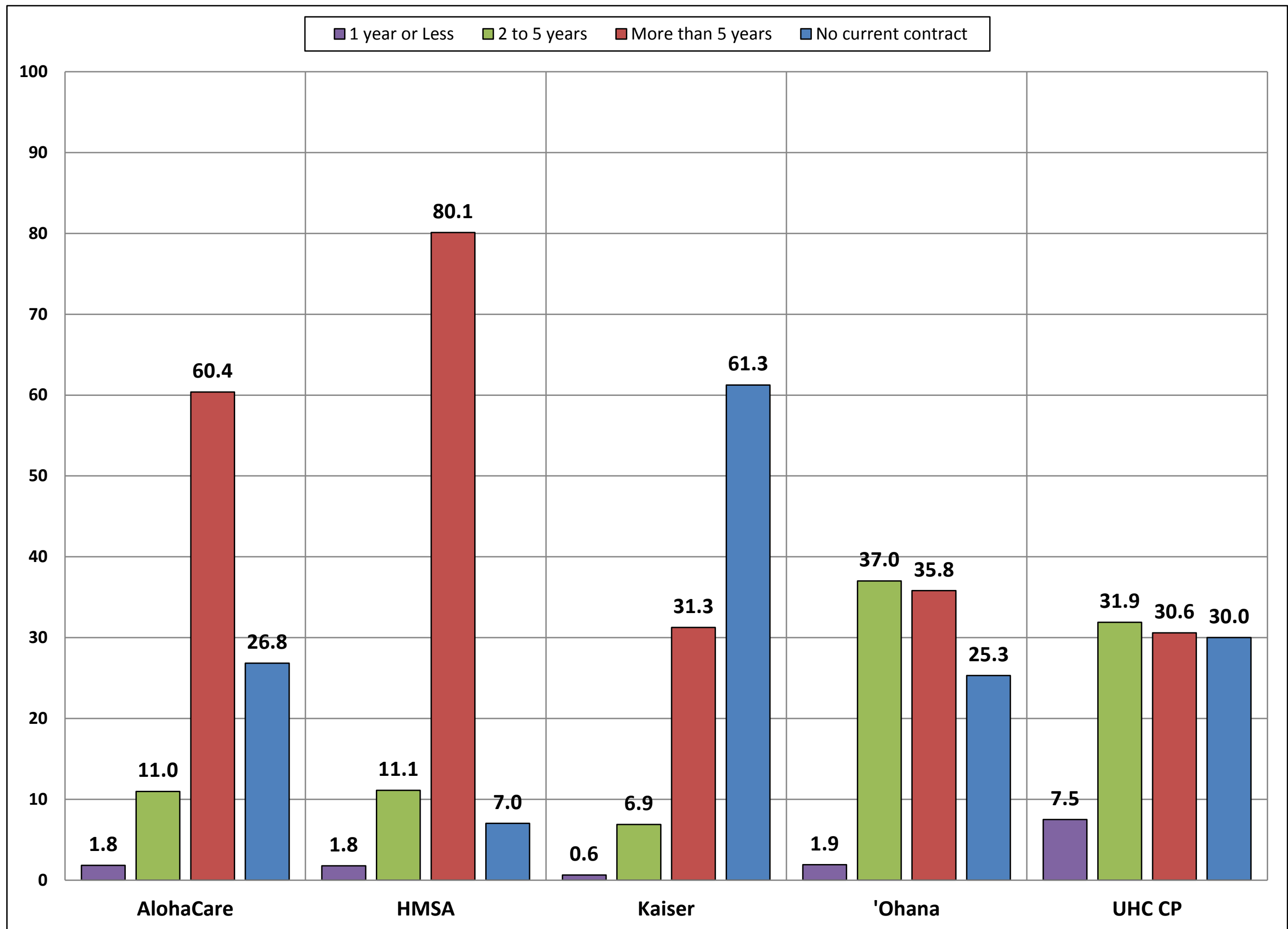
Provider Demographics

The following section presents the demographic characteristics of providers who completed the survey. Table 2-2 presents the provider type demographics at the sample level (i.e., Kaiser and non-Kaiser). Figure 2-1, on the following page, presents the contract length at the health-plan level for providers who completed the survey.

Table 2-2—Provider Demographics: Provider Type		
Provider Type	**Kaiser**	**Non-Kaiser**
Primary Care Provider	33.3%	33.6%
Specialist	66.7%	66.4%

Figure 2-1 depicts the contract length providers have with each health plan.

Figure 2-1—Provider Demographics: Length of Contract



Note: Percentages may not total 100.00% due to rounding.

3. Results

The following section presents the 2013 Hawaii Provider Survey results. The results of the 2013 Hawaii Provider Survey questions are presented by the following seven domains of satisfaction:

- **General Positions**—presents providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation; and providers' level of satisfaction with the timeliness of claims payments.
- **Providing Quality Care**—presents providers' level of satisfaction with the health plans' prior authorization process, referral process, and formulary, in terms of having an impact on providers' abilities to deliver quality care.
- **Health Plan Communication**—presents providers' satisfaction ratings with the knowledge and expertise of health plan staff.
- **Formulary**—presents providers' level of satisfaction with access to formulary and non-formulary drugs.
- **Case Management**—presents providers' level of satisfaction with access to case management services.
- **Specialists**—presents providers' level of satisfaction with the health plans' number of specialists, referral policies for specialists, and number of behavioral health specialists.
- **Behavioral Health**—presents providers' satisfaction ratings with behavioral health policies in terms of integration of care and treatment and communication with primary care providers.

Provider Survey Analysis

Response options to each question within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied. For each question, the percentage of respondents in each response category was calculated. Health plan survey responses are limited to those providers that indicated they had a contract with a QUEST or QExA health plan in Question 1 of the survey. For example, if a provider indicated that he/she did not have a current contract with AlohaCare in Question 1, his/her responses would not be included in the questions pertaining to AlohaCare, if a response had been provided. Therefore, providers may not have rated every health plan on every survey question. Furthermore, if a provider belonged to more than one health plan, he/she may have answered a question for multiple health plans.

Bar graphs depict the health plans' results for each response category. Standard tests of statistical significance were conducted, where applicable, to determine if statistically significant differences in health plan performance exist.[3-1] As is standard in most survey implementations, a "top-box" rate is defined by a positive or satisfied response. Statistically significant differences between the health plans' top-box responses are noted with directional triangles. A health plan's top-box rate that was significantly higher than the aggregate of the other health plans is noted with an upward (▲) triangle. A health plan's top-box rate that was significantly lower than the aggregate of the other health plans is noted with a downward (▼) triangle. A health plan's top-box rate that was not significantly different than the aggregate of the other health plans is noted with a dash (—).

Further, each health plan's 2013 Provider Survey results were compared to its corresponding 2011 Provider Survey results, where applicable, to determine if there were statistically significant differences.[3-2] Statistically significant differences between the health plan's 2013 top-box rates and 2011 top-box rates are noted with directional arrows. Top-box rates that were statistically higher in 2013 than in 2011 are noted with an upward (↑) arrow. Top-box rates that were statistically lower in 2013 than in 2011 are noted with a downward (↓) arrow.

For additional information on the methodology, please refer to the Reader's Guide Section of the report beginning on page 5-1.

[3-1] Due to the small number of total respondents for Kaiser, extreme caution should be exercised when interpreting the health plan's results.
[3-2] The Provider Survey was not administered in 2012.

Findings

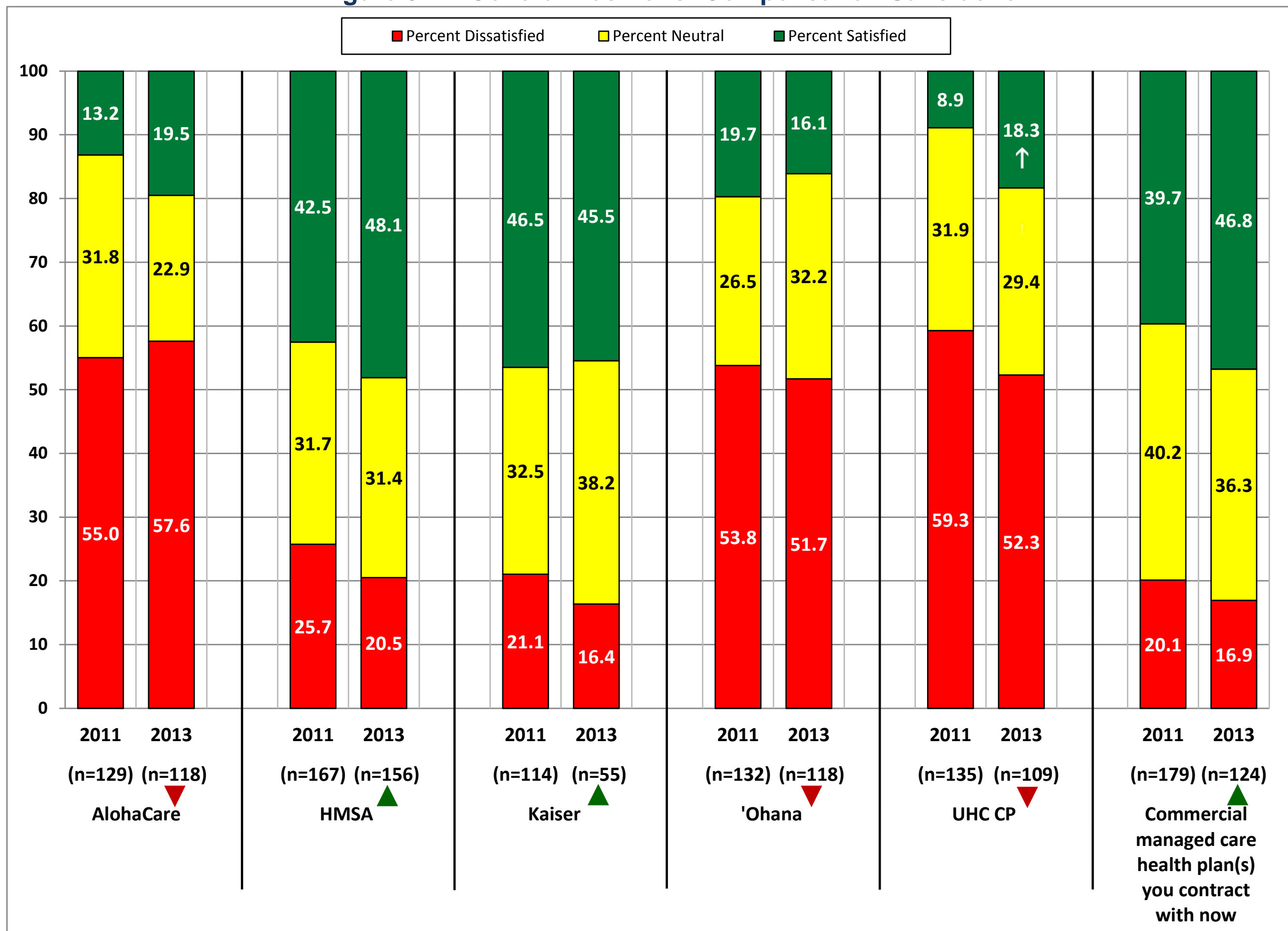
General Positions

Providers were asked to rate their satisfaction with the rate of reimbursement or compensation they receive from their contracted health plans. Responses were classified into the three response categories as follows:

- **Satisfied**—Very Satisfied/Satisfied
- **Neutral**—Neutral
- **Dissatisfied**—Very Dissatisfied/Dissatisfied

Figure 3-1 depicts the response category proportions for each health plan and commercial managed care health plans.

Figure 3-1—General Positions: Compensation Satisfaction



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*

— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*

↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

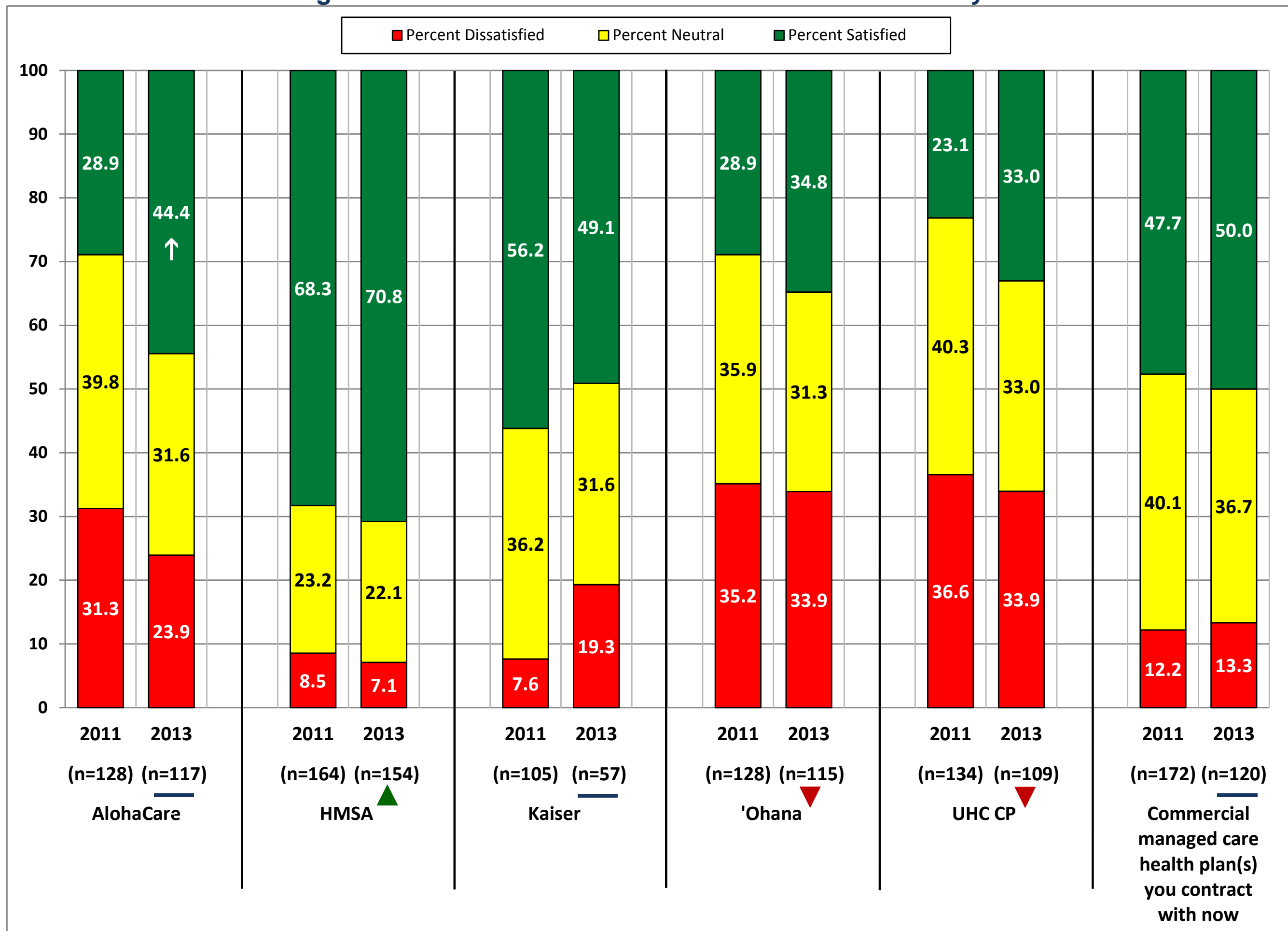
- AlohaCare's top-box rate for reimbursement/compensation (19.5 percent) was significantly lower than the aggregate of the other health plans.
- HMSA's top-box rate for reimbursement/compensation (48.1 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser's top-box rate for reimbursement/compensation (45.5 percent) was significantly higher than the aggregate of the other health plans.
- 'Ohana's top-box rate for reimbursement/compensation (16.1 percent) was significantly lower than the aggregate of the other health plans.
- UHC CP's top-box rate for reimbursement/compensation (18.3 percent) was significantly lower than the aggregate of the other health plans. However, UHC CP's 2013 top-box rate for reimbursement/compensation was significantly higher than its 2011 top-box rate.
- Providers' satisfaction with commercial managed care health plans' reimbursement/ compensation (46.8 percent) was significantly higher than the aggregate of the other health plans.

Providers were asked to rate their satisfaction with the timeliness of claims payments from their contracted health plans. Responses were classified into the three response categories as follows:

- **Satisfied**—Very Satisfied/Satisfied
- **Neutral**—Neutral
- **Dissatisfied**—Very Dissatisfied/Dissatisfied

Figure 3-2 depicts the response category proportions for each health plan and commercial managed care health plans.

Figure 3-2—General Positions: Timeliness of Claims Payments



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

- AlohaCare's top-box rate for timeliness of claims payments increased significantly from 2011 to 2013 (28.9 percent to 44.4 percent, respectively).
- HMSA's top-box rate for timeliness of claims payments (70.8 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser's top-box rate for timeliness of claims payments (49.1 percent) was not significantly higher or lower than the aggregate of the other health plans.
- 'Ohana's top-box rate for timeliness of claims payments (34.8 percent) was significantly lower than the aggregate of other health plans.
- UHC CP's top-box rate for timeliness of claims payments (33.0 percent) was significantly lower than the aggregate of other health plans.

Providing Quality Care

Providers were asked what methods they use to complete prior authorizations and referrals. Response options included: electronic, paper, and by phone. Table 3-1 presents the distribution of prior authorization and referral methods.

Table 3-1—Prior Authorization and Referral Methods

Method	Prior Authorization	Referral
Electronic	44.8%	35.8%
Paper	73.0%	72.8%
By Phone	49.7%	56.3%

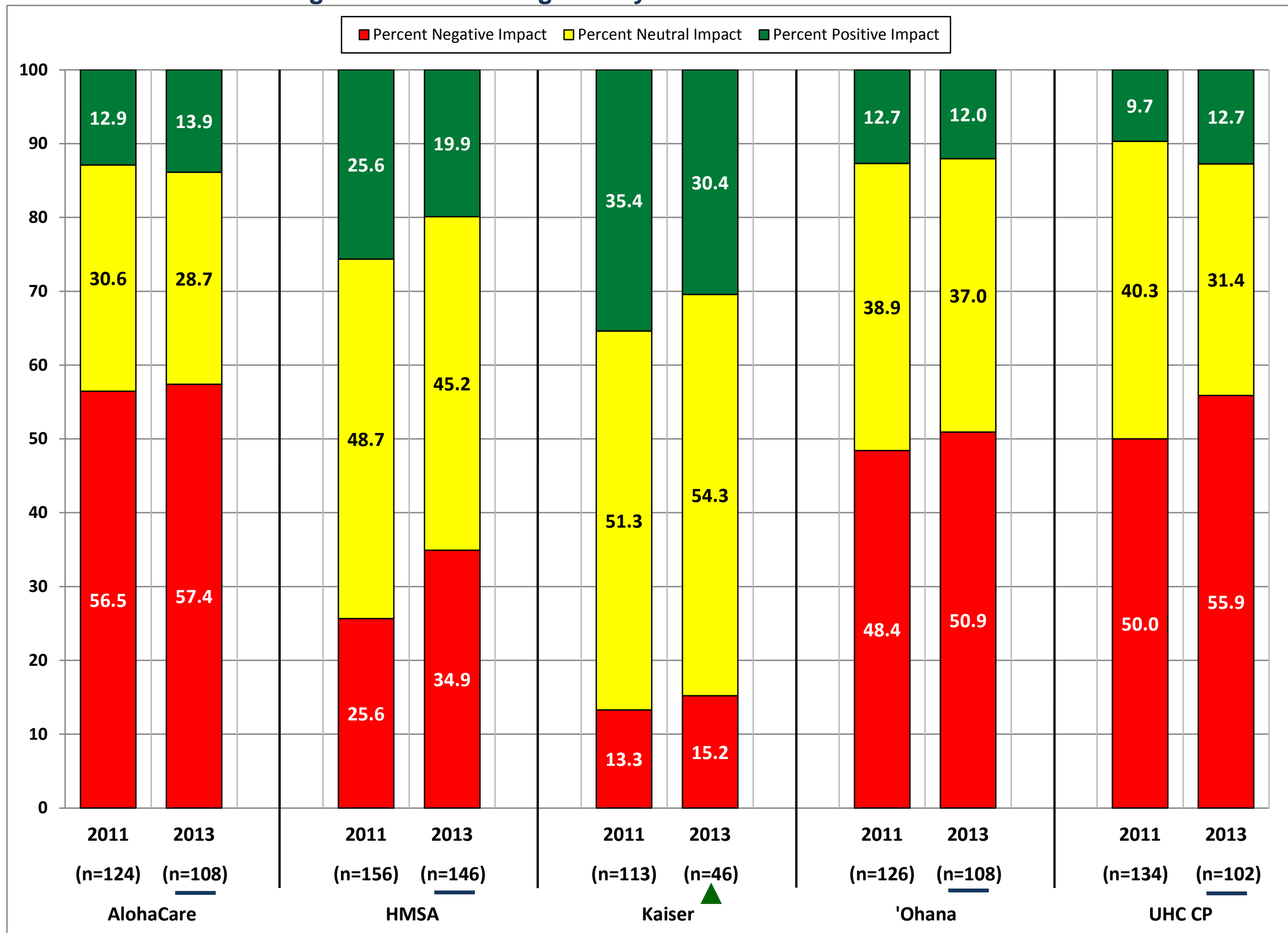
Note: Providers may have marked more than one method for prior authorization and/or referral; therefore, percentages will not total 100.00%.

Providers were also asked three questions focusing on the impact health plans have on their ability to provide quality care. Areas rated included: prior authorization process, referral process, and formulary. Responses were classified into the three response categories as follows:

- **Positive Impact**—Strong Positive Impact/Positive Impact
- **Neutral Impact**—Little or No Impact
- **Negative Impact**—Strong Negative Impact/Negative Impact

Figure 3-3 through Figure 3-5, on the following pages, depict the response category proportions for each health plan.

Figure 3-3—Providing Quality Care: Prior Authorization Process



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*

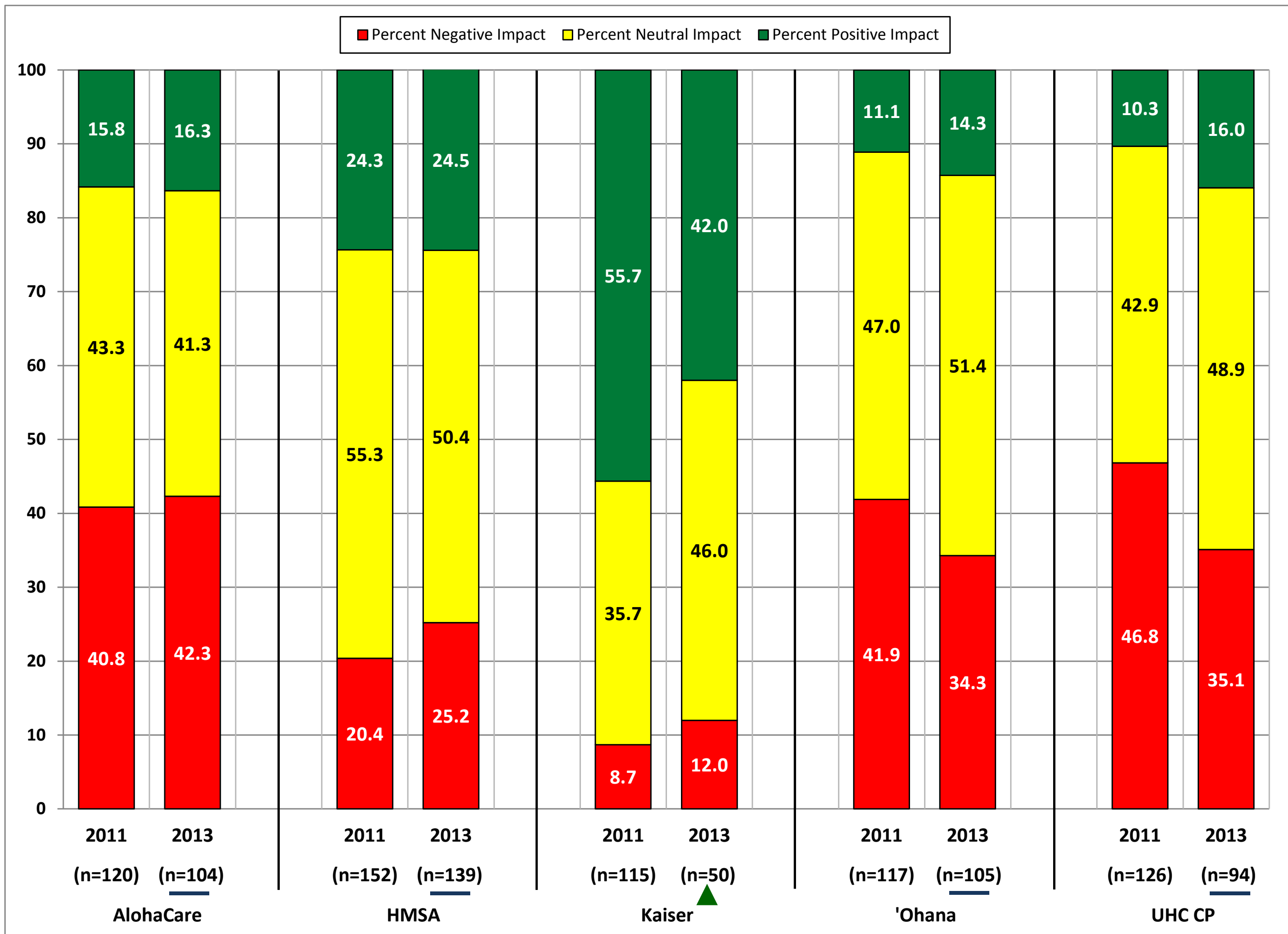
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*

↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

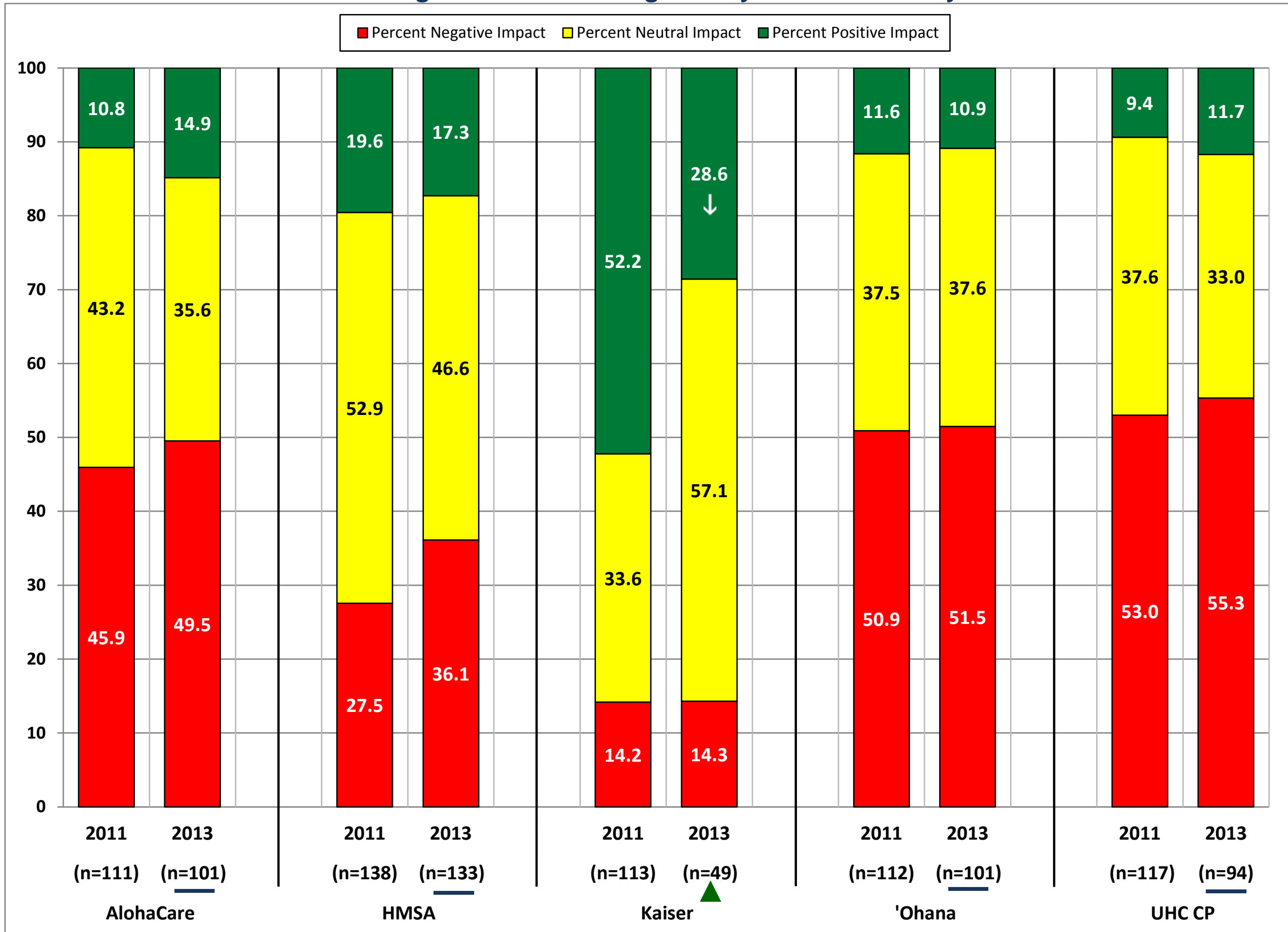
Figure 3-4—Providing Quality Care: Referral Process



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

Figure 3-5—Providing Quality Care: Formulary



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

- AlohaCare's top-box rates for prior authorization process, referral process, and formulary (13.9 percent, 16.3 percent, and 14.9 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rates for prior authorization process, referral process, and formulary (19.9 percent, 24.5 percent, and 17.3 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- Kaiser's top-box rates for prior authorization process, referral process, and formulary (30.4 percent, 42.0 percent, and 28.6 percent, respectively) were significantly higher than the aggregate of the other health plans. However, Kaiser's 2013 top-box rate for formulary was significantly lower than its 2011 top-box rate.
- 'Ohana's top-box rates for prior authorization process, referral process, and formulary (12.0 percent, 14.3 percent, and 10.9 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- UHC CP's top-box rates for prior authorization process, referral process, and formulary (12.7 percent, 16.0 percent, and 11.7 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.

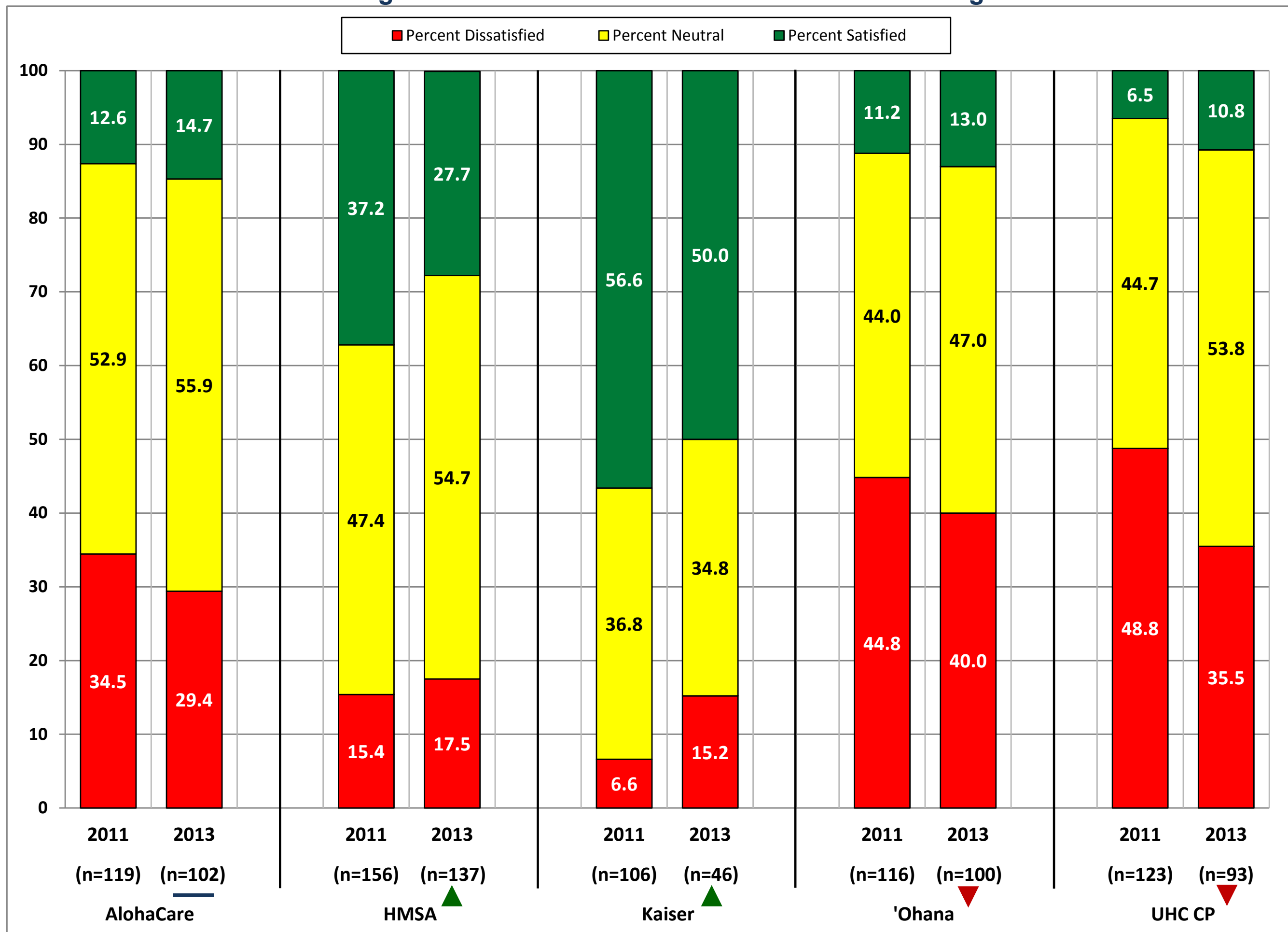
Health Plan Communication

Providers were asked one question to assess the knowledge and expertise of the people they interact with at the health plans. Responses were classified into the three response categories as follows:

- **Satisfied**—Yes, Definitely
- **Neutral**—Yes, Somewhat
- **Dissatisfied**—No, Generally Does Not

Figure 3-6 depicts the response category proportions for each health plan.

Figure 3-6—Health Plan Communication: Knowledge



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*

— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*

↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

- AlohaCare's top-box rate for knowledge and expertise at the health plan (14.7 percent) was not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rate for knowledge and expertise at the health plan (27.7 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser's top-box rate for knowledge and expertise at the health plan (50.0 percent) was significantly higher than the aggregate of the other health plans.
- ‘Ohana's top-box rate for knowledge and expertise at the health plan (13.0 percent) was significantly lower than the aggregate of the other health plans.
- UHC CP's top-box rate for knowledge and expertise at the health plan (10.8 percent) was significantly lower than the aggregate of the other health plans.

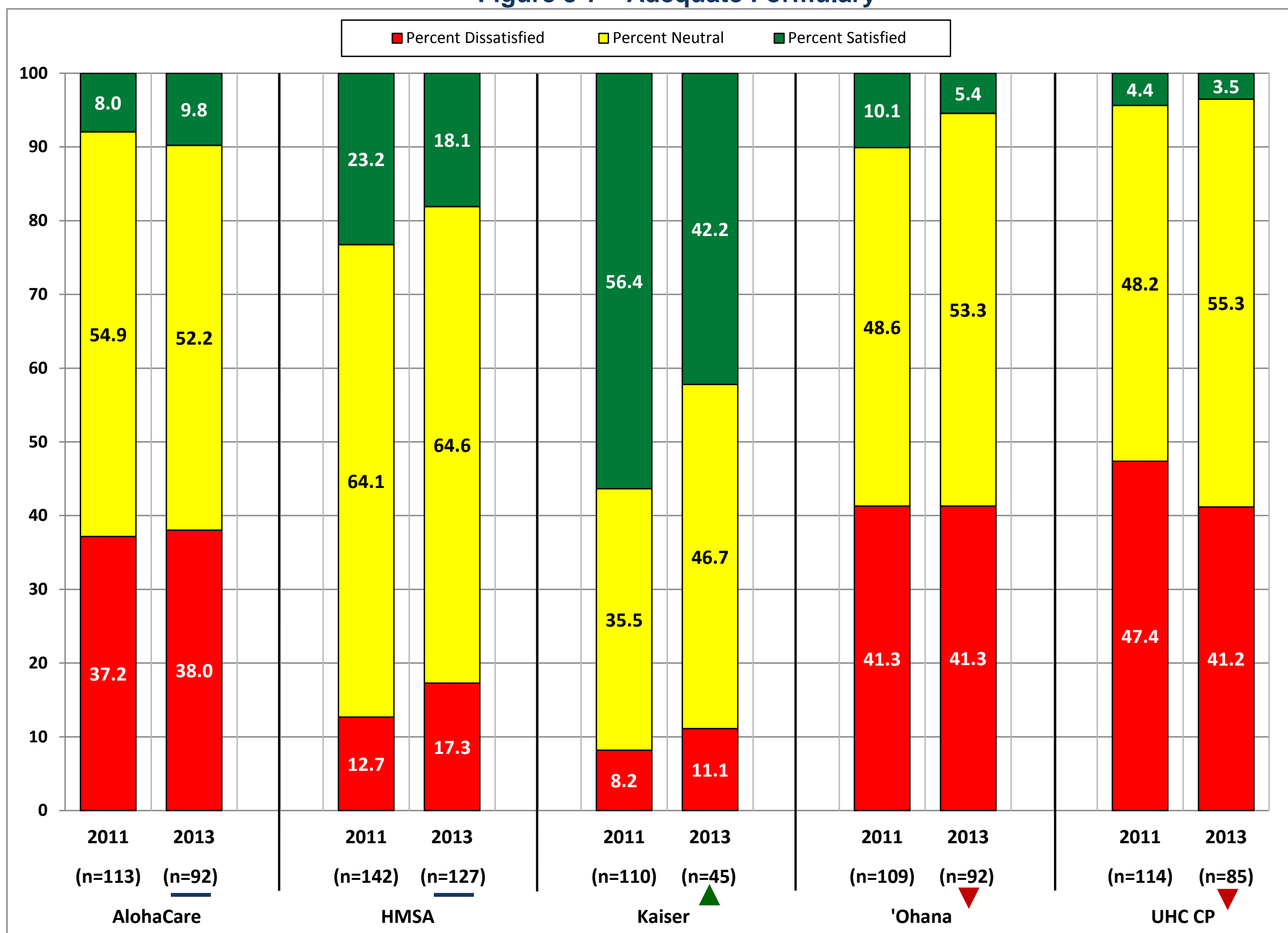
Formulary

Providers were asked two questions to rate the adequacy of the health plans' drug formularies and if the health plans provide adequate access to non-formulary drugs, when needed. Responses were classified into the three response categories as follows:

- **Satisfied**—Yes, Definitely Adequate
- **Neutral**—Yes, Somewhat Adequate
- **Dissatisfied**—No, Not Very Adequate

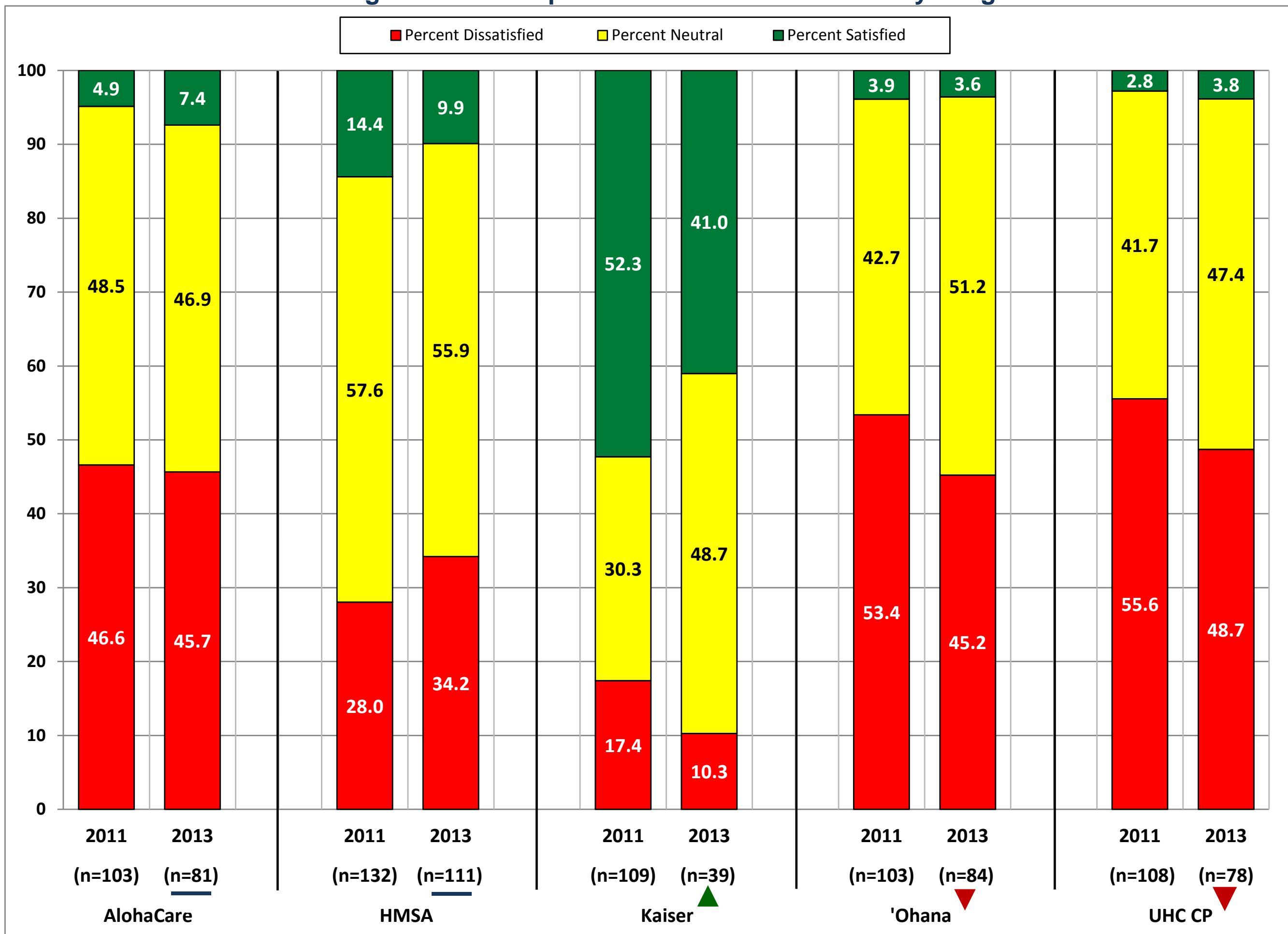
Figure 3-7 and Figure 3-8 depict the response category proportions for each health plan.

Figure 3-7—Adequate Formulary



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*
↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

Figure 3-8—Adequate Access to Non-Formulary Drugs



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

- AlohaCare's top-box rates for adequacy of formulary and access to non-formulary drugs (9.8 percent and 7.4 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rates for adequacy of formulary and access to non-formulary drugs (18.1 percent and 9.9 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- Kaiser's top-box rates for adequacy of formulary and access to non-formulary drugs (42.2 percent and 41.0 percent, respectively) were significantly higher than the aggregate of the other health plans.
- 'Ohana's top-box rates for adequacy of formulary and access to non-formulary drugs (5.4 percent and 3.6 percent, respectively) were significantly lower than the aggregate of the other health plans.
- UHC CP's top-box rates for adequacy of formulary and access to non-formulary drugs (3.5 percent and 3.8 percent, respectively) were significantly lower than the aggregate of the other health plans.

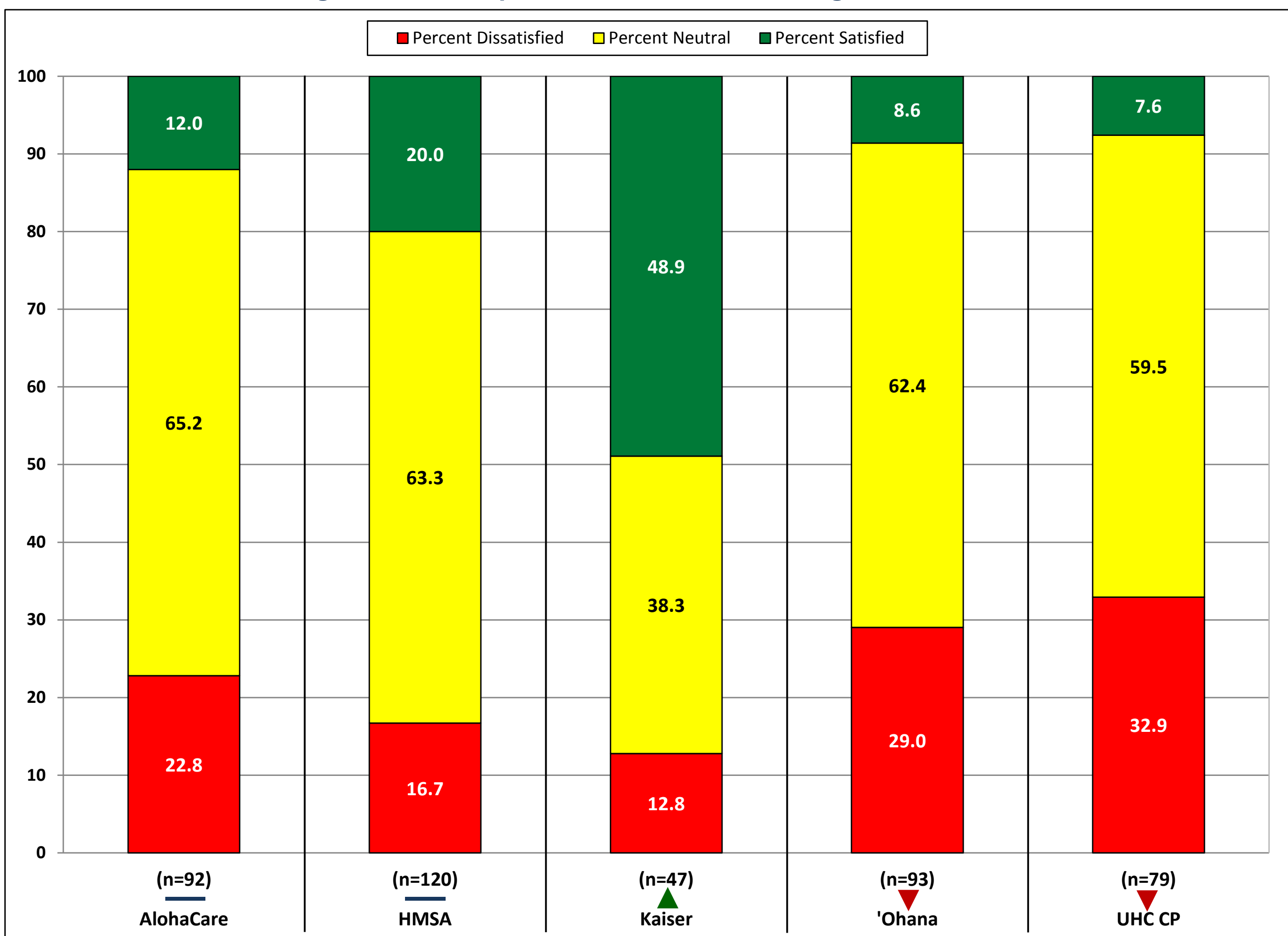
Case Management

Providers were asked to rate the adequacy of access to case management services, when needed. Responses were classified into the three response categories as follows:

- **Satisfied**—Yes, Definitely Adequate
- **Neutral**—Yes, Somewhat Adequate
- **Dissatisfied**—No, Not Very Adequate

Figure 3-9 depicts the response category proportions for each health plan.

Figure 3-9—Adequate Access to Case Management Services[3-3]



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-3] A trend analysis could not be performed for the Adequate Access to Case Management Services measure, since this is a new measure for 2013.

- AlohaCare's top-box rate for access to case management services (12.0 percent) was not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rate for access to case management services (20.0 percent) was not significantly higher or lower than the aggregate of the other health plans.
- Kaiser's top-box rate for access to case management services (48.9 percent) was significantly higher than the aggregate of the other health plans.
- 'Ohana's top-box rate for access to case management services (8.6 percent) was significantly lower than the aggregate of the other health plans.
- UHC CP's top-box rate for access to case management services (7.6 percent) was significantly lower than the aggregate of the other health plans.

Specialists

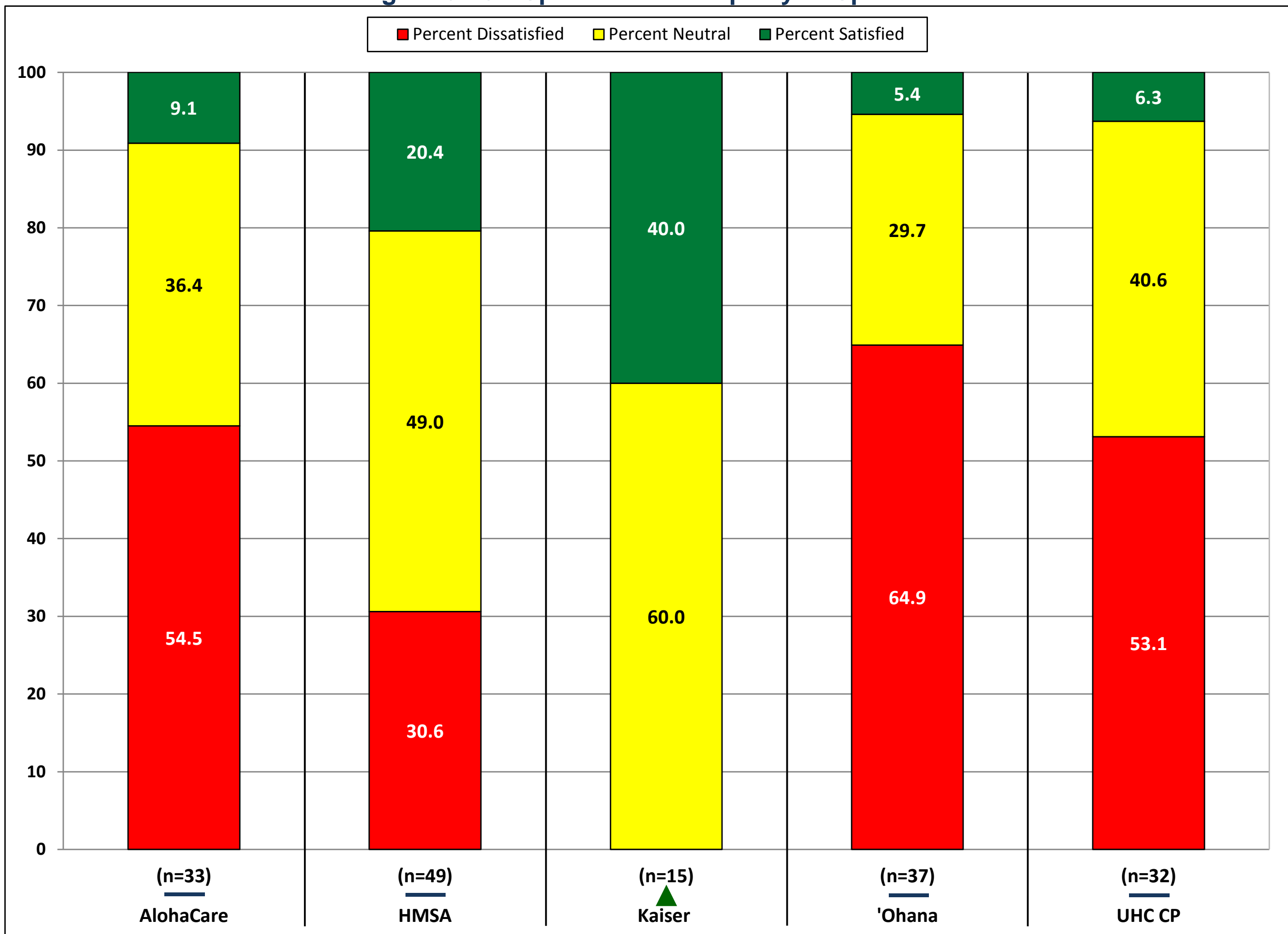
Providers were asked three questions with regard to the health plans' specialists.[3-4] Providers were asked to rate the adequacy of the amount of specialists, the health plans' referral policies for specialists, and the adequacy of the amount of behavioral health specialists. Responses were classified into the three response categories as follows:

- **Satisfied**—Yes, Definitely Adequate/Yes, Definitely Works Well
- **Neutral**—Yes, Somewhat Adequate/Yes, Works Somewhat Well
- **Dissatisfied**—No, Not Very Adequate/No, Does Not Work Very Well

Figure 3-10 through Figure 3-12, on the following pages, depict the response category proportions for each health plan.

[3-4] For 2013, the survey instrument was modified to ask only primary care providers (PCPs) to rate the health plans' specialists; therefore, survey responses to this set of survey questions are limited those providers who responded "Yes" to Question 13 of the survey. Given this modification to the survey instrument, a trend analysis could not be performed.

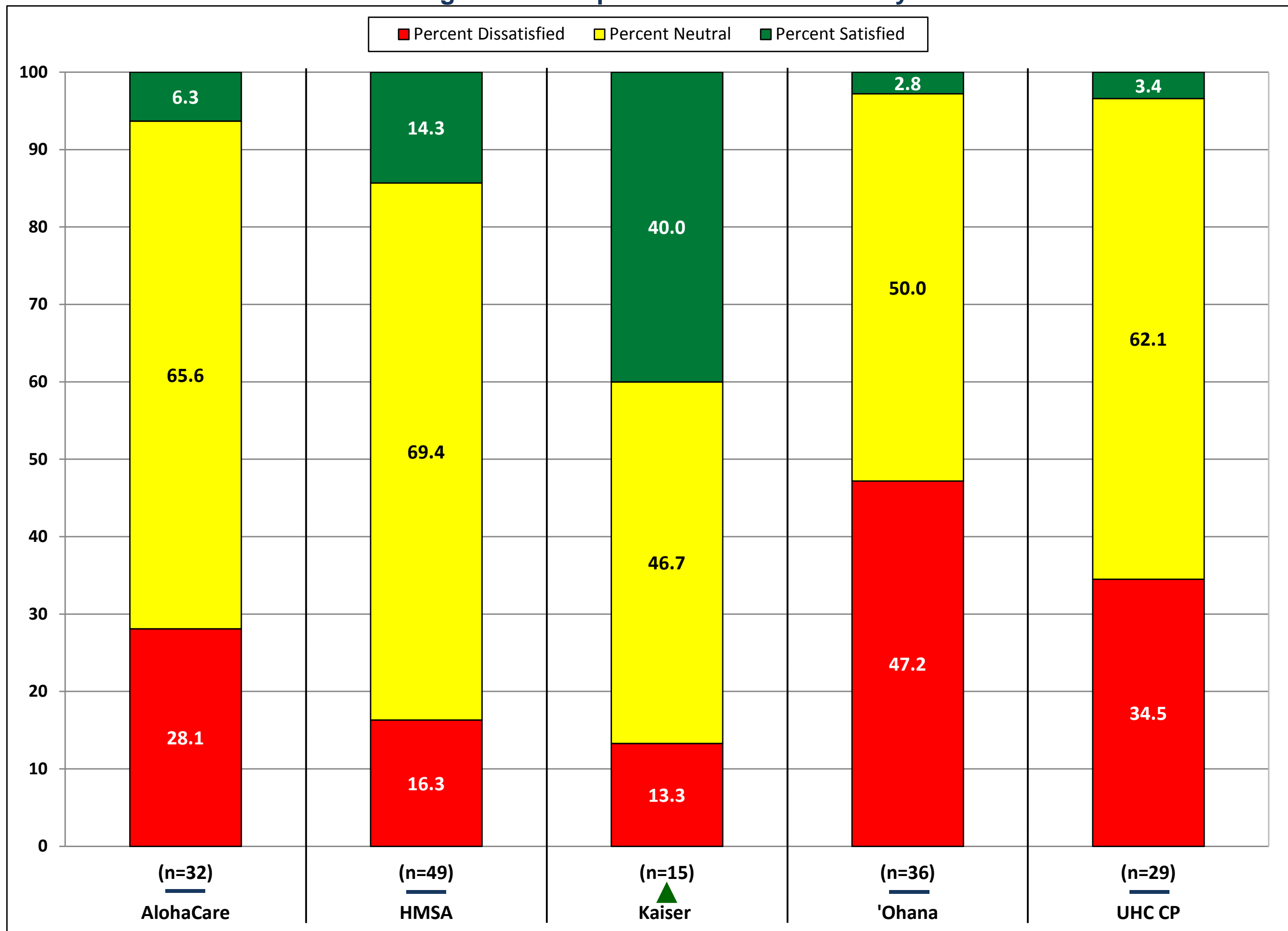
Figure 3-10—Specialists: Adequacy of Specialists[3-5]



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-5] As previously noted, a trend analysis could not be performed for the Adequacy of Specialists measure, given modifications to the survey instrument in 2013.

Figure 3-11—Specialists: Referral Policy[3-6]



Note: Percentages may not total 100.0% due to rounding.

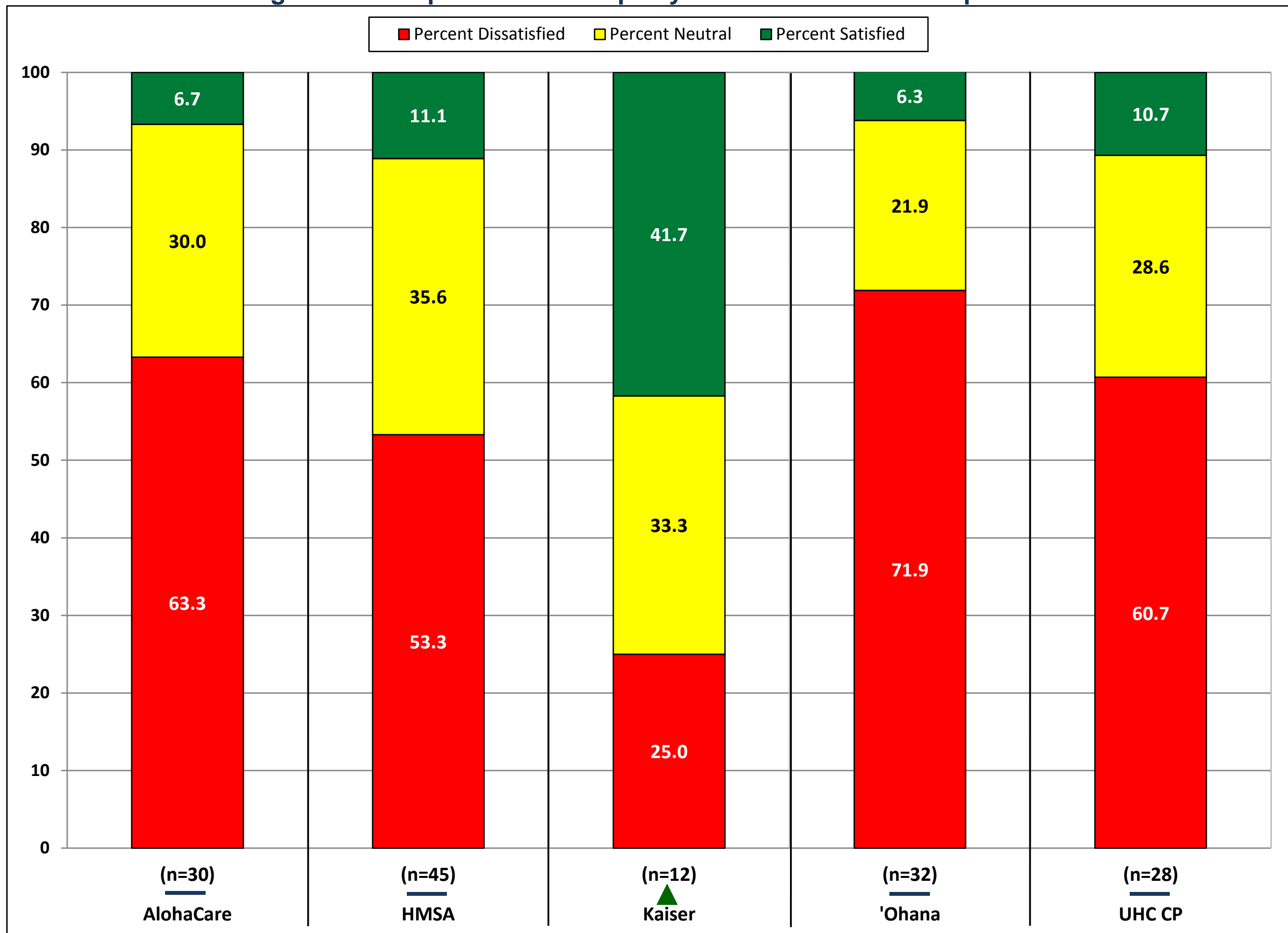
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*

— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-6] As previously noted, a trend analysis could not be performed for the Referral Policy measure, given modifications to the survey instrument in 2013.

Figure 3-12—Specialists: Adequacy of Behavioral Health Specialists[3-7]



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-7] As previously noted, a trend analysis could not be performed for the Adequacy of Behavioral Health Specialists measure, given modifications to the survey instrument in 2013.

- AlohaCare's top-box rates for adequacy of specialists, referral policy, and adequacy of behavioral health specialists (9.1 percent, 6.3 percent, and 6.7 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rates for adequacy of specialists, referral policy, and adequacy of behavioral health specialists (20.4 percent, 14.3 percent, and 11.1 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- Kaiser's top-box rates for adequacy of specialists, referral policy, and adequacy of behavioral health specialists (40.0 percent, 40.0 percent, and 41.7 percent, respectively) were significantly higher than the aggregate of the other health plans.
- 'Ohana's top-box rates for adequacy of specialists, referral policy, and adequacy of behavioral health specialists (5.4 percent, 2.8 percent, and 6.3 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.
- UHC CP's top-box rates for adequacy of specialists, referral policy, and adequacy of behavioral health specialists (6.3 percent, 3.4 percent, and 10.7 percent, respectively) were not significantly higher or lower than the aggregate of the other health plans.

Behavioral Health

Providers were asked four questions focusing on behavioral health care services. Providers were asked if they were a behavioral health provider. Table 3-2 presents the percentage who answered "Yes" (i.e., behavioral health provider) or "No" (i.e., not a behavioral health provider).

Table 3-2—Behavioral Health: Provider Type	
Behavioral Health Provider	21.3%
Not a Behavioral Health Provider	78.7%

Behavioral health providers were asked if the health plans promoted coordination of care between behavioral health care specialists and primary care providers (PCPs). Table 3-3 presents the proportion of providers who answered "Yes" (i.e., plan promotes coordination of care) or "No" (i.e., plan does not promote coordination of care).[3-8]

Table 3-3—Behavioral Health: Coordination of Care	
Plan Promotes Coordination of Care	47.1%
Plan Does Not Promote Coordination of Care	52.9%

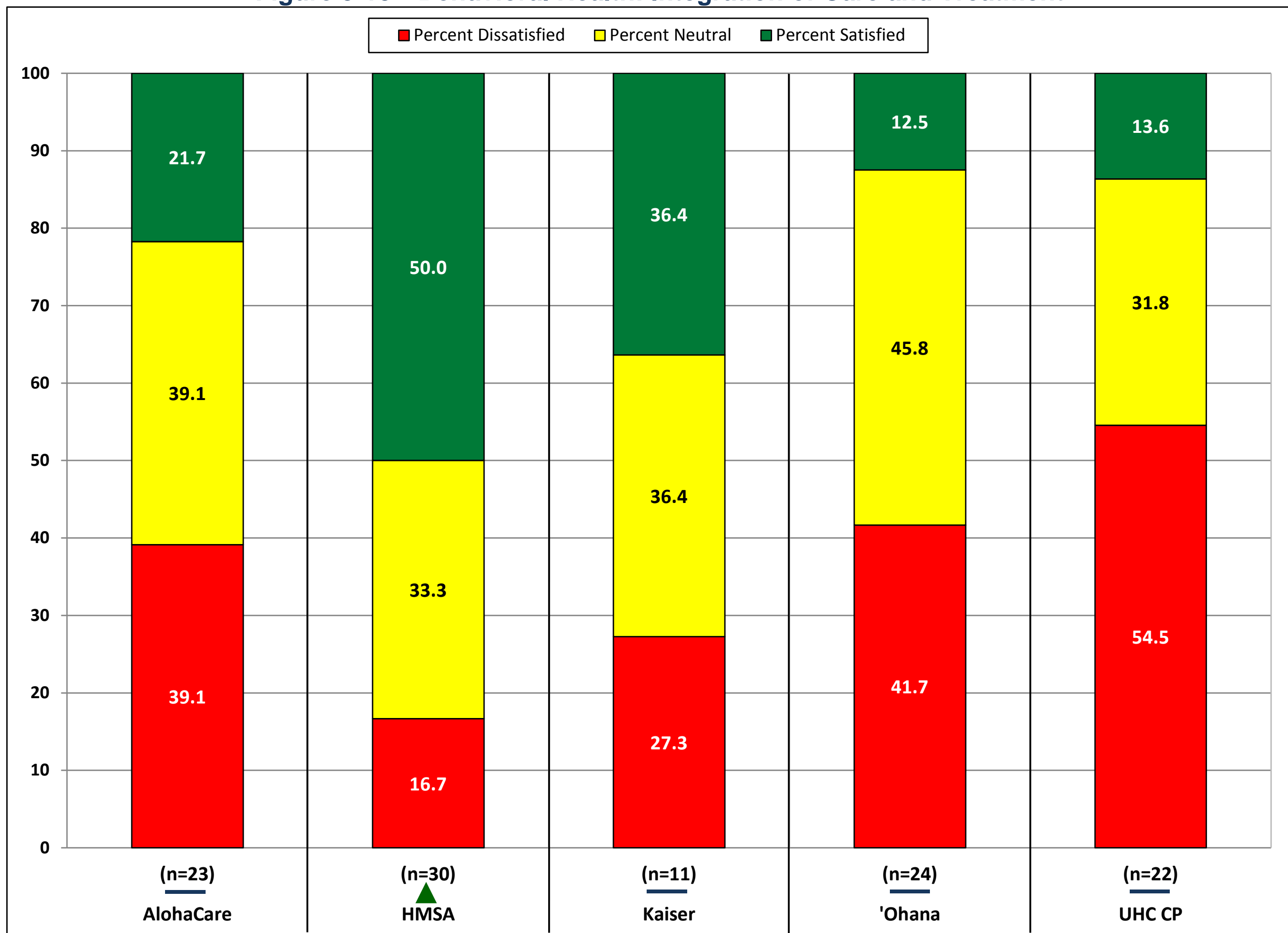
[3-8] Results are based on providers who indicated that they were a behavioral health provider (i.e., answered "Yes" to Question 17 in the survey).

Providers were asked to rate the health plans' policies for integration of behavioral and physical health care and treatment, in terms of allowing coordination of health care services with patients' PCPs, when needed. Additionally, providers were asked to rate the health plans' communication policies, in terms of letting behavioral health care specialists share information with patients' PCPs, when needed.[3-9] Responses were classified into the three response categories as follows:

- **Satisfied**—Yes, Definitely Works Well
- **Neutral**—Yes, Works Somewhat Well
- **Dissatisfied**—No, Does Not Work Very Well

Figure 3-13 and Figure 3-14 depict the response category proportions for each health plan.

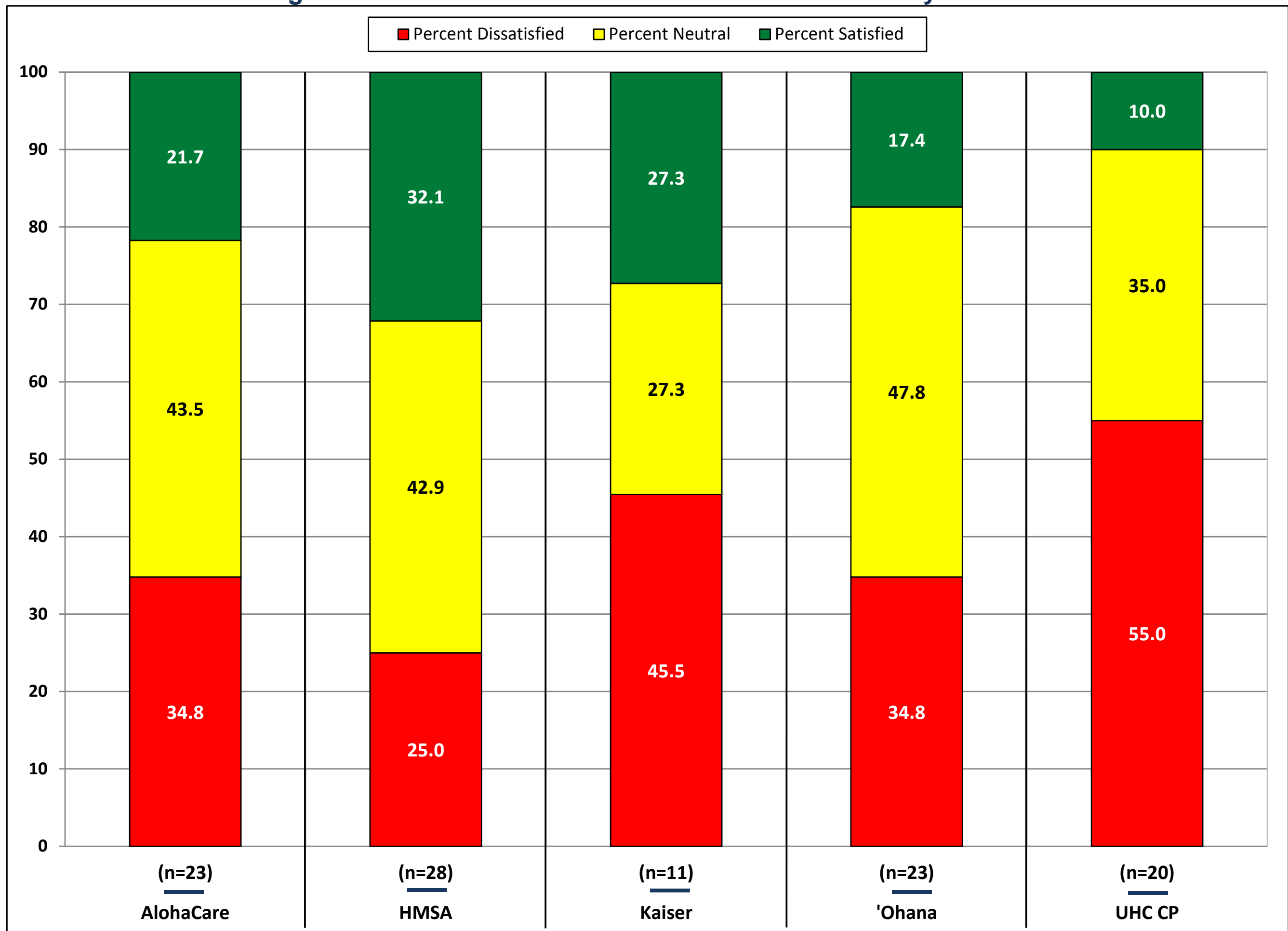
Figure 3-13—Behavioral Health: Integration of Care and Treatment[3-10]



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-9] Health plan survey results are limited to those providers that indicated they were a behavioral health provider.
[3-10] A trend analysis could not be performed for the Integration of Care and Treatment measure, since this is a new measure for 2013.

Figure 3-14—Behavioral Health: Communication Policy[3-11]



Note: Percentages may not total 100.0% due to rounding.
▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans*
— *indicates the health plan's top-box rate is not significantly different than the aggregate of the other health plans*
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans*

[3-11] A trend analysis could not be performed for the Communication Policy measure, since this is a new measure for 2013.

- AlohaCare's top-box rates for integration of care and treatment (21.7 percent) and communication policy (21.7 percent) were not significantly higher or lower than the aggregate of the other health plans.
- HMSA's top-box rate for integration care and treatment (50.0 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser's top-box rates for integration of care and treatment (36.4 percent) and communication policy (27.3 percent) were not significantly higher or lower than the aggregate of the other health plans.
- 'Ohana's top-box rates for integration of care and treatment (12.5 percent) and communication policy (17.4 percent) were not significantly higher or lower than the aggregate of the other health plans.
- UHC CP's top-box rates for integration of care and treatment (13.6 percent) and communication policy (10.0 percent) were not significantly higher or lower than the aggregate of the other health plans.

Summary of Results

Table 3-4 presents a summary of the statistically significant differences that exist between the "top-box" rates of the health plans.[3-12]

Table 3-4—Plan Comparisons

	AlohaCare	HMSA	Kaiser	‘Ohana	UHC CP
General Positions[3-13]					
Compensation Satisfaction	▼	▲	▲	▼	▼
Timeliness of Claims Payments	—	▲	—	▼	▼
Providing Quality Care					
Prior Authorization Process	—	—	▲	—	—
Referral Process	—	—	▲	—	—
Formulary	—	—	▲	—	—
Health Plan Communication					
Knowledge	—	▲	▲	▼	▼
Formulary					
Adequate Formulary	—	—	▲	▼	▼
Adequate Access to Non-Formulary Drugs	—	—	▲	▼	▼
Case Management					
Adequate Access to Case Management Services	—	—	▲	▼	▼
Specialists					
Adequacy of Specialists	—	—	▲	—	—
Referral Policy	—	—	▲	—	—
Adequacy of Behavioral Health Specialists	—	—	▲	—	—
Behavioral Health					
Integration of Care and Treatment	—	▲	—	—	—
Communication Policy	—	—	—	—	—

▲ *indicates the plan's performance is significantly higher than the aggregate performance of the other plans*
— *indicates the plan's performance is not significantly different than the aggregate performance of the other plans*
▼ *indicates the plan's performance is significantly lower than the aggregate performance of the other plans*

[3-12] Due to the small number of total respondents for Kaiser, extreme caution should be exercised when interpreting the health plan's results.

[3-13] For purposes of the Compensation Satisfaction and Timeliness of Claims Payments plan comparisons, the plans' results were compared to the aggregate performance of the other Medicaid health plans and contracted commercial managed care health plans.

The following is a summary of the health plans' performance on the 14 measures evaluated for statistical differences.

- AlohaCare's performance was significantly lower than the aggregate performance of the other plans on one measure.
- HMSA's performance was significantly higher than the aggregate performance of the other plans on four measures.
- Kaiser's performance was significantly higher than the aggregate performance of the other plans on 11 measures.
- 'Ohana's performance was significantly lower than the aggregate performance of the other plans on six measures.
- UHC CP's performance was significantly lower than the aggregate performance of the other plans on six measures.

Table 3-5 provides the highlights of the statistically significant results from the trend analysis.[3-14,3-15]

Table 3-5—Trend Analysis					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
General Positions					
Compensation Satisfaction	⇔	⇔	⇔	⇔	↑
Timeliness of Claims Payments	↑	⇔	⇔	⇔	⇔
Providing Quality Care					
Prior Authorization Process	⇔	⇔	⇔	⇔	⇔
Referral Process	⇔	⇔	⇔	⇔	⇔
Formulary	⇔	⇔	↓	⇔	⇔
Health Plan Communication					
Knowledge	⇔	⇔	⇔	⇔	⇔
Formulary					
Adequate Formulary	⇔	⇔	⇔	⇔	⇔
Adequate Access to Non-Formulary Drugs	⇔	⇔	⇔	⇔	⇔
Case Management					
Adequate Access to Case Management Services					
Specialists					
Adequacy of Specialists					
Referral Policy					
Adequacy of Behavioral Health Specialists					
Behavioral Health					
Integration of Care and Treatment					
Communication Policy					

↑ *indicates the 2013 top-box rate is significantly higher than the 2011 top-box rate*
⇔ *indicates the 2013 top-box rate is not significantly different than the 2011 top-box rate*
↓ *indicates the 2013 top-box rate is significantly lower than the 2011 top-box rate*

[3-14] It should be noted that a trend analysis could not be performed for the Adequate Access to Case Management Services, Integration of Care and Treatment, and Communication Policy measures, since they are new measures for 2013.
[3-15] Given modifications made to the survey instrument, a trend analysis could not be performed for the Adequacy of Specialists, Referral Policy, and Adequacy of Behavioral Health Specialists measures in 2013.

Comparison of the health plans' 2013 top-box rates to their corresponding 2011 top-box rates on the eight measures evaluated for statistically significant differences revealed the following summary results:

- AlohaCare scored significantly higher in 2013 than in 2011 on one measure, Timeliness of Claims Payments.
- HMSA did not score significantly higher or lower in 2013 than in 2011 on any of the measures.
- Kaiser scored significantly lower in 2013 than in 2011 on one measure, Providing Quality Care: Formulary.
- 'Ohana did not score significantly higher or lower in 2013 than in 2011 on any of the measures.
- UHC CP scored significantly higher in 2013 than in 2011 on one measure, Compensation Satisfaction.

Quality Improvement Recommendations

The Provider Survey revealed that there is an opportunity for the QUEST and QExA plans to improve provider satisfaction.

Kaiser's performance was significantly higher than the aggregate performance of the other plans on nearly all domains. ‘Ohana and UHC CP exhibited the most opportunity for improvement, performing significantly lower than the aggregate performance of the other plans on over 40 percent of the measures.

Based on these results, the following are general QI recommendations that plans and the MQD should consider to increase or maintain a high level of provider satisfaction.[4-1] The MQD and each plan should evaluate these general recommendations in the context of their own operational and QI activities.

- Providers consistently expressed concerns about difficulties in specialty and behavioral health referrals. Health plans could conduct an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization are approved. For those specialty categories and medical services that have high approval rates, the plans could explore the option of no longer requiring a referral or authorization in order to streamline the processes and have a more positive impact on providers' abilities to supply quality care.
- Providers' feedback indicated that opportunities exist to ensure that health plans have an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary. The MQD could review the formulary list on a regular basis in order to ensure that the list is updated to include essential medications that follow standard treatment guidelines. The MQD should consider working with the health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- To address providers' concerns with timeliness and burden of authorization and referral systems, health plans not currently using electronic systems for providers should consider automating these processes. Automation of these processes can help facilitate patient care and allow for efficient communication with providers. An electronic referral tool, such as a Web-based system, would allow providers to submit authorization and referral requests and receive approvals (e.g., approval letter) electronically. Automating these processes also can: 1) minimize the number of human touches required for patient authorization, referral, and claims processing; 2) reduce the time required for providers to receive an authorization; 3) improve the timeliness of patient care; and 4) improve claims processing.
- Opportunities exist based on providers' feedback to ensure health plan staff have the knowledge and expertise to address providers' questions and concerns regarding health plan policies and procedures. Health plans could provide educational sessions to ensure the staff are up-to-date and well-informed about information on patient care and services requested by

[4-1] Brodsky, Karen L. “Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions.” *HealthWorks Consulting, LLC*, 2005.

providers. Staff should be knowledgeable of basic information, such as, patient benefits, claims and billing, and provisions related to prior authorizations and referrals.

- Health plans could employ periodic provider focus groups to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the health plans in understanding and targeting areas needing performance improvement. Health plans could then utilize a performance improvement project approach to determine interventions and perform a targeted re-measurement of provider satisfaction at a later date.

Future Survey Administration Recommendations for the MQD

HSAG recommends continued administration of the Provider Survey every two years. This re-measurement would provide valuable trending information to the MQD, providers, the general public, as well as the QUEST and QExA health plans. Trending the data will allow health plans to see which areas they have improved on and which areas require direct improvement efforts. HSAG also recommends that the MQD continue to oversample in order to increase the number of providers that participate in the survey.

HSAG recommends that the MQD employ alternative approaches to increase provider participation in the survey. Increasing the overall number of respondents to the survey reduces the likelihood of non-response bias and increases the likelihood that the responses reflect those of all providers serving Med-QUEST members. Some specific recommended strategies follow:

- HSAG recommends that the MQD collect e-mail addresses for its QUEST and QExA providers and/or work with the health plans to obtain this contact information to ensure this information is captured in its provider database system from which the provider survey sample is taken.
- A Web-based survey is an easy and convenient way for providers to respond to the survey. The combination of a mixed-mode approach (e.g., mail survey, e-mail reminders, or Web-based survey) can help to yield higher response rates. The potential for initial distribution of the survey via provider e-mail as opposed to only mailed paper copies would increase the likelihood of higher response rates by allowing ease of access to the Web-based component of the survey. An e-mail with a direct link to the Web-based survey and customized to include a provider's specific login promotes provider participation by allowing immediate and convenient access to the Web-based survey.
- Informing providers that a survey will be coming can greatly increase the number of responses. A survey announcement, in the form of a letter or an e-mail, could be sent from the MQD prior to administration of the survey informing health plans and/or providers about the upcoming survey and the estimated timeline for arrival. Additionally, the survey announcement could include information on when and how results will be made available. In the reminder notice, the MQD could stress the importance of provider participation and encourage them to complete the survey when it arrives. This would augment the current cover letter included with the survey. Furthermore, the MQD could work with health plans and request that the health plans send reminder notifications to providers, or publish an announcement in provider newsletters, encouraging them to participate in the survey.

- Given that the provider network structure may vary among health plans (e.g., staff models vs. network models), the MQD may want to explore methods for ensuring all eligible providers are included in the survey sample, as well as methods for revising the survey instrument to ensure survey questions are applicable to all provider respondents.
- HSAG further recommends that the MQD consider developing a methodology for inclusion of individual practitioners working as PCPs or specialists at the federally qualified health centers (FQHCs) in its Medicaid registered provider database system, and therefore, ensuring their inclusion in the sample frame. By contract, the MQD allows FQHCs to function as a PCP for enrolled members, and most of the health plans utilize one or more of the FQHCs in this role, some extensively. It is important to be able to include these practitioners in the survey sample to obtain a truer picture of providers' perceptions. Currently, only those providers who also maintain an outside office practice in addition to their FQHC practice are listed as individual practitioners in the State's Medicaid provider database and included in the population from which the survey sample is drawn. Ensuring these FQHC providers are included in future provider survey sample frames would also ensure better representation of the entire PCP and specialist network used by the health plans.

5. Reader's Guide

This section provides a comprehensive overview of the survey administration protocol and analytic methodology employed for this study. It is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Survey Administration

HSAG, in collaboration with the MQD, developed a survey instrument to collect the most meaningful data possible. The 2013 Hawaii Provider Survey included 21 questions that surveyed providers on a broad range of topics.

Sampling Procedures

Hawaii providers eligible for sampling included PCPs and specialists who served the Medicaid population during the study period, were contracted with at least one of the QUEST or QExA health plans, and were included on the Medicaid registered provider listing provided by the MQD for HSAG's sampling. HSAG performed a simple random sample of 400 Kaiser providers and 1,100 non-Kaiser (i.e., AlohaCare, HMSA, 'Ohana, and/or UHC CP) providers, for a total of 1,500 providers. The non-Kaiser providers could not be stratified for sampling by health plan due to the limitations of the sample frame data provided by the MQD.

Survey Protocol

The survey administration consisted of mailing surveys to the sampled providers. Each provider was sent the survey questionnaire, a cover letter from the MQD, and a postage-paid reply envelope. There were two options for providers to complete the survey: (1) complete the paper-based survey and return it in the pre-addressed, postage-paid return envelope, or (2) complete the Web-based survey by logging on to the survey Web site with a designated provider-specific login. Approximately four weeks after the first survey was mailed to providers, a second copy of the survey questionnaire was mailed to non-respondents.

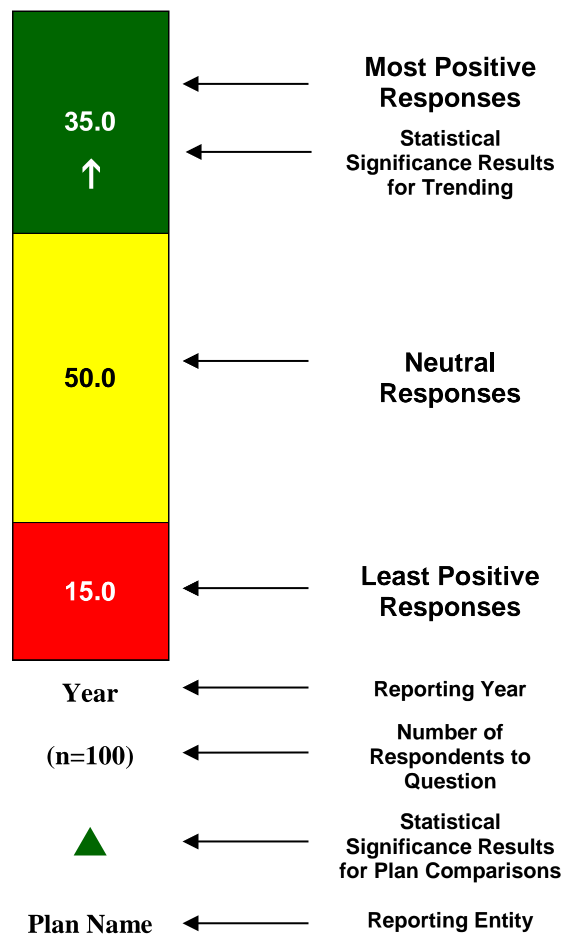
HSAG sampled providers who met the following criteria:

- Served the Hawaii Medicaid population.
- Provided service to QUEST or QExA members as of December 31, 2012.
- Provided service to at least one of the following health plans: AlohaCare, HMSA, Kaiser, 'Ohana, and/or UHC CP.

How to Read the Satisfaction Bar Graphs

The bar graphs in this section have three response categories. The least positive responses to the survey questions are at the bottom of the bar in red. Neutral responses fall between the least positive and the most positive responses and are in the middle of the bar in yellow. The most positive responses to the survey questions are at the top of the bar in green. The most positive responses also are referred to as "top-box" responses.

Below is an explanation of how to read the satisfaction bar graphs presented throughout the Results Section.



Methodology

Response Rates

The administration of the Hawaii Provider Survey was designed to achieve the highest possible response rate. The response rate is defined as the total number of completed surveys divided by all eligible providers of the sample. Eligible providers included the entire random sample minus any providers that could not be surveyed due to incorrect contact information or did not have a current contract with any of the health plans.

$$\text{Response Rate} = \frac{\text{Number of Completed Surveys}}{\text{Total Random Sample} - \text{Ineligibles}}$$

A total of 184 Hawaii providers completed a survey, including 24 providers from the Kaiser sample and 160 providers from the non-Kaiser sample. The overall response rate of 13.8 percent is below the normal range of provider survey response rates that HSAG has observed in other states.

Response Category Proportions

Where applicable, response category proportions were calculated for each survey item. Table 5-1 presents how the response categories were assigned.

Table 5-1—Response Category Assignments	
Response Category	**Assignment**
Very Dissatisfied	Dissatisfied Response
Dissatisfied	Dissatisfied Response
Neutral	Neutral Response
Satisfied	Satisfied Response
Very Satisfied	Satisfied Response
No, Generally Does Not	Dissatisfied Response
Yes, Somewhat	Neutral Response
Yes, Definitely	Satisfied Response
No, Not Very Adequate	Dissatisfied Response
Yes, Somewhat Adequate	Neutral Response
Yes, Definitely Adequate	Satisfied Response
No, Does Not Work Very Well	Dissatisfied Response
Yes, Works Somewhat Well	Neutral Response
Yes, Definitely Works Well	Satisfied Response
Strong Negative Impact	Negative Impact Response
Negative Impact	Negative Impact Response
Little or No Impact	Neutral Impact Response
Positive Impact	Positive Impact Response
Strong Positive Impact	Positive Impact Response

For the survey items, response category proportions were calculated using a standard question summary rate formula. In other words, separate response category proportions (or question summary rates) were calculated for each of the response categories (e.g., satisfied, neutral, and dissatisfied). Responses that fell into a response category were assigned a 1, while all others were assigned a 0. These values were summed to determine a response category score.

The question summary rate was the response category score divided by the total number of responses to a question. Therefore, the response category proportions total 100 percent.

$$\text{Question Summary Rate (QSR)} = \sum_{i}^{n} \frac{x}{n}$$

i = 1, …, n providers responding to question
x = response category score (either 0 or 1)

Plan Comparisons

Chi square (χ^2) tests were performed on each measure to determine if significant performance differences existed between the plans. For purposes of this analysis, responses were categorized into one of two response categories: positive response and non-positive response. Each health plan's responses were compared to the aggregate results of the other health plans, excluding the health plan being analyzed. For example, an analysis of AlohaCare's results would include a comparison to the aggregate of all other health plans, excluding AlohaCare.

The test statistic for the χ^2 test is:

$$\chi^2 = \sum \left[\frac{(O_i - E_i)^2}{E_i} \right]$$

where O_i is the observed frequency for the *i*th category of the variable of interest and E_i is the expected frequency for the *i*th category. χ^2 will be small if the frequencies exhibit small differences (i.e., larger *p* value) and large if the frequencies exhibit large differences (i.e., small *p* value). For purposes of this evaluation, a *p* value less than 0.05 is defined as a statistically significant difference.

In the bar graphs, statistically significant differences are noted with directional triangles. A health plan's top-box rates that was significantly higher than the aggregate rate of the other health plans is noted with an upward (▲) triangle. A health plan's top-box rate that was significantly lower than the aggregate rate of the other health plans is noted with a downward (▼) triangle. A health plan's top-box rate that was not significantly different than the aggregate rate of the other health plans is noted with a dash (—).

Trend Analysis

Each health plan's 2013 Provider Survey results were compared to its corresponding 2011 Provider Survey results, where applicable, to determine if there were statistically significant differences.[5-1]

[5-1] The Provider Survey was not administered in 2012.

Statistically significant differences between the health plan's 2013 top-box rates and 2011 top-box rates are noted with directional arrows. Top-box rates that were statistically higher in 2013 than in 2011 are noted with an upward (↑) arrow. Top-box rates that were statistically lower in 2013 than in 2011 are noted with a downward (↓) arrow.

Limitations and Cautions

The findings presented in the 2013 Hawaii Provider Survey Report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings presented. These limitations are discussed below.

Non-Response Bias

The experiences of the provider respondent population may be different than that of non-respondent providers with respect to their personal experiences and may vary by plan. Therefore, the potential for non-response bias should be considered when interpreting these results.

Single Point-in-Time

The results of the survey provide a snapshot comparison of provider satisfaction for each health plan, according to providers that completed the survey, at a single point-in-time. These comparisons may not reflect stable patterns of providers' experiences over time.

Causal Inferences

Although the survey examines whether providers report differences in satisfaction with various aspects of the health plans, these differences may not be completely attributable to the health plans. These analyses identify whether providers give different ratings of satisfaction. The survey by itself does not reveal why the differences exist.

Multi-Plan Participation

Caution should be taken when reviewing the results presented in this report. Since providers may participate in more than one QUEST or QExA health plan, the providers' responses toward a given health plan may be affected by their experiences with either: 1) a different health plan or 2) the QUEST and QExA programs. Therefore, any differences reported may be due to additional factors that were not captured in this survey.

Kaiser Results

Due to the small number of Kaiser provider respondents, extreme caution should be exercised when interpreting the health plan's results given the increased potential for non-response bias and likelihood that responses are not reflective of all Kaiser providers serving Med-QUEST members.

6. Survey Instrument

This section provides a copy of the survey instrument used during this study.

2013 HAWAII PROVIDER'S SURVEY

1. Please indicate how **long you (or your group) have been contracting with each health plan**. If a health plan is listed below that you do not currently contract with, please mark "no current contract" and leave your answer blank for this health plan in the rest of the questionnaire.

	One year or less	Two to five years	More than five years	No current contract
1a. AlohaCare	○	○	○	○
1b. HMSA	○	○	○	○
1c. Kaiser	○	○	○	○
1d. 'Ohana	○	○	○	○
1e. UHC CP[1]	○	○	○	○

2. How would you describe your satisfaction with **the rate of reimbursement (pay schedule) or compensation** you get from each of the following:

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
2a. AlohaCare	○	○	○	○	○
2b. HMSA	○	○	○	○	○
2c. Kaiser	○	○	○	○	○
2d. 'Ohana	○	○	○	○	○
2e. UHC CP	○	○	○	○	○
2f. Commercial managed care health plan(s) you contract with now	○	○	○	○	○

3. How would you describe your satisfaction with **the timeliness of claims payments** for each of the following:

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
3a. AlohaCare	○	○	○	○	○
3b. HMSA	○	○	○	○	○
3c. Kaiser	○	○	○	○	○
3d. 'Ohana	○	○	○	○	○
3e. UHC CP	○	○	○	○	○
3f. Commercial managed care health plan(s) you contract with now	○	○	○	○	○

[1] UnitedHealthcare Community Plan (UHC CP) was previously referred to as Evercare. In December 2011, Evercare changed its name to UHC CP.

4. What methods do you use to complete prior authorizations? (Select all that apply)

- ○ Electronic
- ○ Paper
- ○ By Phone

5. What has been the impact of the health plan's **prior authorization process** on your ability to provide quality care for your patients in the health plan?

	Strong negative impact	Negative impact	Little or no impact	Positive impact	Strong positive impact
5a. AlohaCare	○	○	○	○	○
5b. HMSA	○	○	○	○	○
5c. Kaiser	○	○	○	○	○
5d. 'Ohana	○	○	○	○	○
5e. UHC CP	○	○	○	○	○

6. What methods do you use to complete referrals? (Select all that apply)

- ○ Electronic
- ○ Paper
- ○ By Phone

7. What has been the impact of the health plan's **referral process** on your ability to provide quality care for your patients in the health plan?

	Strong negative impact	Negative impact	Little or no impact	Positive impact	Strong positive impact
7a. AlohaCare	○	○	○	○	○
7b. HMSA	○	○	○	○	○
7c. Kaiser	○	○	○	○	○
7d. 'Ohana	○	○	○	○	○
7e. UHC CP	○	○	○	○	○

8. During the last 12 months, what has been the impact of the health plan's **formulary** on your ability to provide quality care for your patients in the health plan?

	Strong negative impact	Negative impact	Little or no impact	Positive impact	Strong positive impact
8a. AlohaCare	○	○	○	○	○
8b. HMSA	○	○	○	○	○
8c. Kaiser	○	○	○	○	○
8d. 'Ohana	○	○	○	○	○
8e. UHC CP	○	○	○	○	○

9. When you need to discuss a patient's course of care or denial of services by the health plan, does the person you speak with at the health plan have the **necessary professional knowledge and expertise**?

	NO, generally does not	YES, somewhat	YES, definitely
9a. AlohaCare	○	○	○
9b. HMSA	○	○	○
9c. Kaiser	○	○	○
9d. 'Ohana	○	○	○
9e. UHC CP	○	○	○

10. Does the health plan have an **adequate formulary**?

	NO, not very adequate	YES, somewhat adequate	YES, definitely adequate
10a. AlohaCare	○	○	○
10b. HMSA	○	○	○
10c. Kaiser	○	○	○
10d. 'Ohana	○	○	○
10e. UHC CP	○	○	○

11. Does the health plan provide **adequate access to non-formulary drugs** for patients in circumstances where you feel they are needed?

	NO, not very adequate	YES, somewhat adequate	YES, definitely adequate
11a. AlohaCare	○	○	○
11b. HMSA	○	○	○
11c. Kaiser	○	○	○
11d. 'Ohana	○	○	○
11e. UHC CP	○	○	○

12. Does the health plan provide **adequate access to case management services** for patients in circumstances where you feel they are needed?

	NO, not very adequate	YES, somewhat adequate	YES, definitely adequate
12a. AlohaCare	○	○	○
12b. HMSA	○	○	○
12c. Kaiser	○	○	○
12d. 'Ohana	○	○	○
12e. UHC CP	○	○	○

13. Are you a primary care provider (PCP)?

○ Yes ➔ ***Go to Question 14***
○ No ➔ ***Go to Question 17***

14. Does the health plan have an **adequate network of specialists** in terms of having **enough** specialists?

	NO, not very adequate	YES, somewhat adequate	YES, definitely adequate
14a. AlohaCare	○	○	○
14b. HMSA	○	○	○
14c. Kaiser	○	○	○
14d. 'Ohana	○	○	○
14e. UHC CP	○	○	○

15. Does the health plan's policy for **referral to specialists** work well for you in terms of letting you send patients to specialists when you feel this is necessary?

	NO, does not work very well	YES, works somewhat well	YES, definitely works well
15a. AlohaCare	○	○	○
15b. HMSA	○	○	○
15c. Kaiser	○	○	○
15d. 'Ohana	○	○	○
15e. UHC CP	○	○	○

16. Does the health plan have an adequate network of **behavioral health specialists** in terms of having **enough** specialists?

	NO, not very adequate	YES, somewhat adequate	YES, definitely adequate
16a. AlohaCare	○	○	○
16b. HMSA	○	○	○
16c. Kaiser	○	○	○
16d. 'Ohana	○	○	○
16e. UHC CP	○	○	○

17. Are you a behavioral health provider?

- ○ Yes ➔ ***Go to Question 18***
- ○ No ➔ ***Go to Question 21***

18. Does the health plan promote **coordination of care** between behavioral health care specialists and PCPs?

- ○ Yes
- ○ No

19. Does the health plan's policy for **integrating behavioral and physical health care and treatment** work well for you in terms of letting you coordinate health care services with patients' PCPs when you feel this is necessary?

	NO, does not work very well	YES, works somewhat well	YES, definitely works well
19a. AlohaCare	○	○	○
19b. HMSA	○	○	○
19c. Kaiser	○	○	○
19d. 'Ohana	○	○	○
19e. UHC CP	○	○	○

20. Does the health plan's policy for **communication among behavioral health care specialists and PCPs** work well for you in terms of letting you share information with patients' PCPs when you feel this is necessary?

	NO, does not work very well	YES, works somewhat well	YES, definitely works well
20a. AlohaCare	○	○	○
20b. HMSA	○	○	○
20c. Kaiser	○	○	○
20d. 'Ohana	○	○	○
20e. UHC CP	○	○	○

21. We welcome your comments - please write them on the lines below.

____

____

____

____

____

Thank you for sharing your experience and opinions! Your answers are greatly appreciated.

When you are done, please use the enclosed postage-paid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

Results will be available on the Med-QUEST Division Web site after January 1, 2014.

http://www.med-quest.us/