Hawaii QUEST Expanded
Section 1115 Draft Annual Report
June 26, 2015

Demonstration Reporting Period:
Demonstration Year: 20 (7/1/2013 – 6/30/2014)

Table of Contents

Introduction....1
Health Delivery System....2
Operational/Policy Developments/Issues....3
Outreach/Enrollment Activities....4
Outcomes, Quality and Access to Care....5
Measures....5
Recent Initiatives on Measures....31
Cost of Care....43
Audits and Lawsuits....45
Demonstration Programmatic Information specific to QUEST Expanded Demonstration....46
Status of the Demonstration Evaluation....50
MQD Contact(s)....50
Attachments
Attachment A HEDIS Measures- QUEST and QExA programs- 2014
Attachment B 2014 Hawaii CAHPS Star Reports- Adult
Attachment C Summary of Financial Expenditures- DY 20
Attachment D QUEST and QExA Dashboards- July 1 to December 31, 2013 summary
Attachment E QUEST and QExA Dashboards- January 1 to June 30, 2014 summary

Introduction

During this reporting period, Hawaii renewed its demonstration on September 23, 2013 to start a new demonstration called QUEST Integration.

Hawaii's QUEST Integration is a Department of Human Services (DHS), Med-QUEST Division (MQD) comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. In 1994, the MQD converted approximately 108,000 recipients from three public funded medical assistance programs into the initial demonstration including 70,000 Aid to Families with Dependent Children (AFDC-related) individuals; 19,000 General Assistance program individuals (of which 9,900 were children whom the MQD was already receiving Federal financial participation); and 20,000 former MQD funded SCHIP program individuals.

QUEST Integration is a continuation and expansion of the state's ongoing demonstration that is funded through Title XIX, Title XXI and the State. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations. During the period between approval and implementation of the QUEST Integration managed care contract the state will continue operations under its QUEST and QUEST Expanded Access (QExA) programs. The current extension period began on October 1, 2013.

The State's goals in the demonstration are to:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP);
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS;
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

Health Delivery System

The State of Hawaii's 1115(a) demonstration has two programs: QUEST and QUEST Expanded Access (QExA). The QUEST program is for children and adults who are under the age of 65 and do not have a disability. The QExA program is for adults 65 years and older and children or adults with a disability. Table 1 provides a list of enrollment by program.

Both the QUEST and QExA programs are managed care delivery systems. Enrollment into managed care is mandatory.

The QUEST program has five health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. MQD enacted the commencement of services to members for the current contract of the QUEST program on July 1, 2012. This contract expires on December 31, 2014.

The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan (formerly Evercare QExA). MQD enacted the commencement of services to members for the current contract of the QExA program on February 1, 2009. This contract expires on June 30, 2011 with three one-year options to extend for the State of Hawaii. DHS has extended this contract for all three one-year extensions until June 30, 2014. DHS obtained an extension of this contract with an expiration of December 31, 2014.

The benefits offered by QUEST and QExA are comprehensive benefit packages. See Table 2 for a list of benefits provided to both QUEST and QExA members. Table 3 contains a list of the carve-out benefits for either QUEST or QExA.

Operational/Policy Developments/Issues

During demonstration year 20, the MQD worked with the QUEST Expanded Access (QExA) health plans on implementation of the QExA program. More about QExA implementation will be included at later parts of the report.

The MQD did not have any major programmatic changes in QUEST or QExA in demonstration year 20.

The MQD performed its fifth year of Pay for Performance in the QUEST program. The MQD is financially incentivizing the QUEST health plans to improve quality in the following areas:

- Childhood Immunizations
- Chlamydia Screening
- Comprehensive Diabetes Care:
  - LDL Control <100 mg/dl
  - HbAIC Control (<8%)
  - Systolic and Diastolic BP Levels <140/90
- Controlling High Blood Pressure
- Getting Needed Care

Measure	Time Frame	AlohaCare	HMSA	Kaiser	'Ohana	United
Childhood Immunization	January to December 2013	No	No	Yes	No	No
Chlamydia Screening in Women	January to December 2013	No	Yes	Yes	No	No
Comprehensive Diabetes Care						
LDL Control <100 mg/dl	January to December 2013	No	No	Yes	No	No
HbA1C Control (<8%)	January to December 2013	No	No	No	No	No
Systolic and Diastolic BP Levels < 140/90	January to December 2013	No	No	Yes	No	No
Controlling High Blood Pressure	January to December 2013	No	No	Yes	No	No
Getting Needed Care	January to December 2013	No	No	No	No	No

The MQD uses both HEDIS and CAHPS survey results to monitor progress in these areas for the QUEST health plans. The QUEST health plans had an opportunity to receive $0.40 PMPM for improvement in each of the areas listed above for a maximum of $2.00 PMPM for January to December 2013. Improvement is not required in all areas to receive the financial incentive.

In demonstration year 20, the health plans received financial incentives for performance improvement (see table above).

Outreach/Enrollment Activities

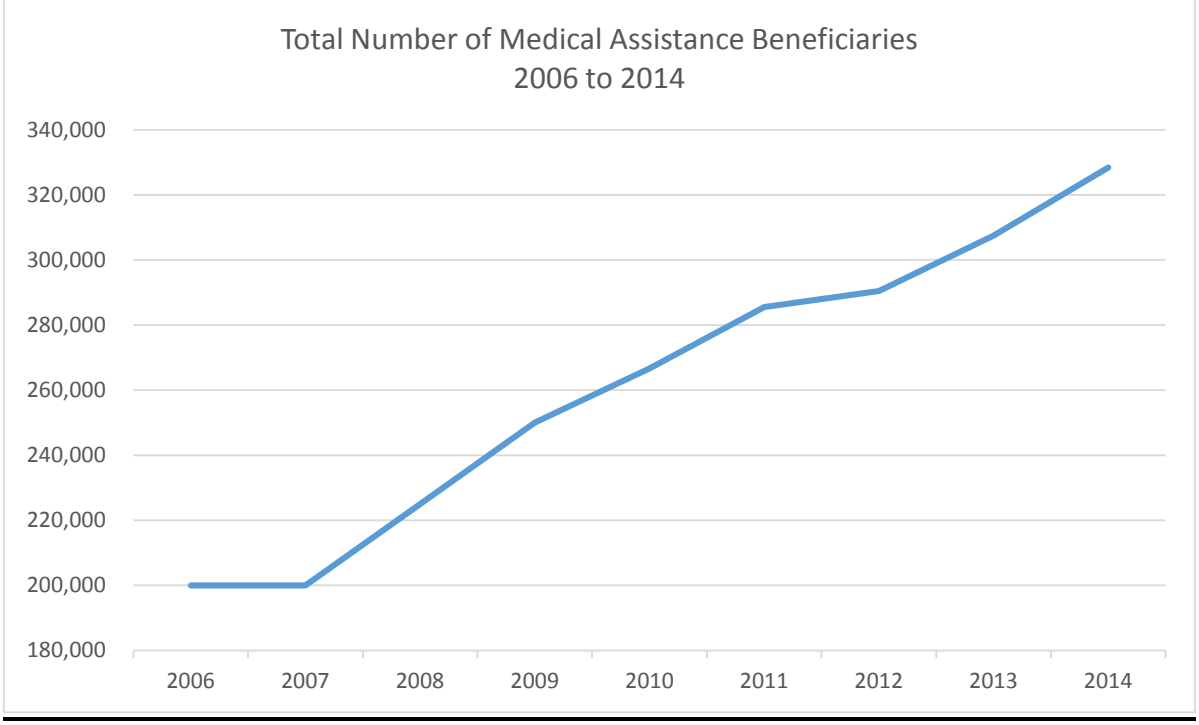
The DHS started determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria on October 1, 2013. In addition, MQD fine-tuned its work within its eligibility system called Kauwale (community) On-Line Eligibility Assistance System (KOLEA). DHS focused applicants to apply on-line at its mybenefits.hawaii.gov website.

The MQD implemented the Affordable Care Act (ACA) requirements in October 1, 2013. This included the FQHCs becoming navigators with the Hawaii Health Connector. Through this process, FQHCs were able to submit applications for Hawaii Medicaid through a portal developed by the Connector.

The Demonstration had a 23.1% percent increase in enrollment over State Fiscal Year 2010. The majority of this enrollment occurred in the QUEST program. See Table 1 for enrollment statistics.

The MQD has had an increase in enrollment of 64% since December 2006. See chart below for visual of the increase in enrollment of the Demonstration program in Hawaii.

At this time, DHS does not have any other outreach services for eligibility applications.



Outcomes, Quality and Access to Care

MQD Quality Strategy

The MQD started working with CMS, with Gary Jackson as the contact, in January 2010 on the revision of the Quality Strategy. MQD followed the CMS toolkit and checklist for State Quality Strategies as well as the Delaware Quality Strategy as a template. In May 2010, MQD submitted the revised Quality Strategy to CMS. The public comment period ended on September 9, 2010 and MQD received approval of its Quality Strategy. A copy of the Quality Strategy is posted at the MQD website (www.med-quest.us).

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. HEDIS measures that the health plans report to us are reviewed and updated each year. A copy of the list of the QUEST and QExA programs' reported HEDIS 2014 measures, including the validated HEDIS 2014 measures, is attached in Attachment A. Below is more detailed information regarding HEDIS.

The MQD performed one Adult and one Child CAHPS surveys in the spring of 2014. The Adult CAHPS survey was for the QUEST and QExA programs and the Child CAHPS survey was for the CHIP enrollees. Members of the QUEST and QExA health plans that are Medicaid adults and children were provided an opportunity to participate in this survey. CHIP enrollees of both QUEST and QExA had their own survey for reporting to CMS. The CHIP report is Statewide and not by health plan due to limited enrollment. See Attachment B for a copy of the QUEST, QExA, and CHIP CAHPS Star Report of the following points of information: Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors' Communicate, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Below is more detailed information regarding the CAHPS survey.

QUEST & QExA HEDIS 2014

The most recent reported HEDIS year for QUEST & QExA is HEDIS 2014. The six EQRO audited scores for this year for the QUEST plans were Childhood Immunization Status (CIS), Well-Child Visits in the First 15 Months of Life (W15), Controlling High Blood Pressure (CBP), Comprehensive Diabetes Care (CDC), Breast Cancer Screening (BCS), and Chlamydia Screening in Women (CHL). The six measures reviewed for the QExA plans were Controlling High Blood Pressure (CBP), Comprehensive Diabetes Care (CDC), Adults' Access to Preventive/Ambulatory Health Services (AAP), Ambulatory Care (AMB), Inpatient Utilization – General Hospital/Acute Care (IPU), and Plan All-Cause Re-Admissions (PCR)

Measures

The graphs used to illustrate the various measures are, unless otherwise noted, scaled from 0% to 100%. This was done to facilitate comparisons between graphs and to present a consistent scale of measurement.

Initiatives related to these measures are reported separately in a subsequent section of this report.

HEDIS Measures

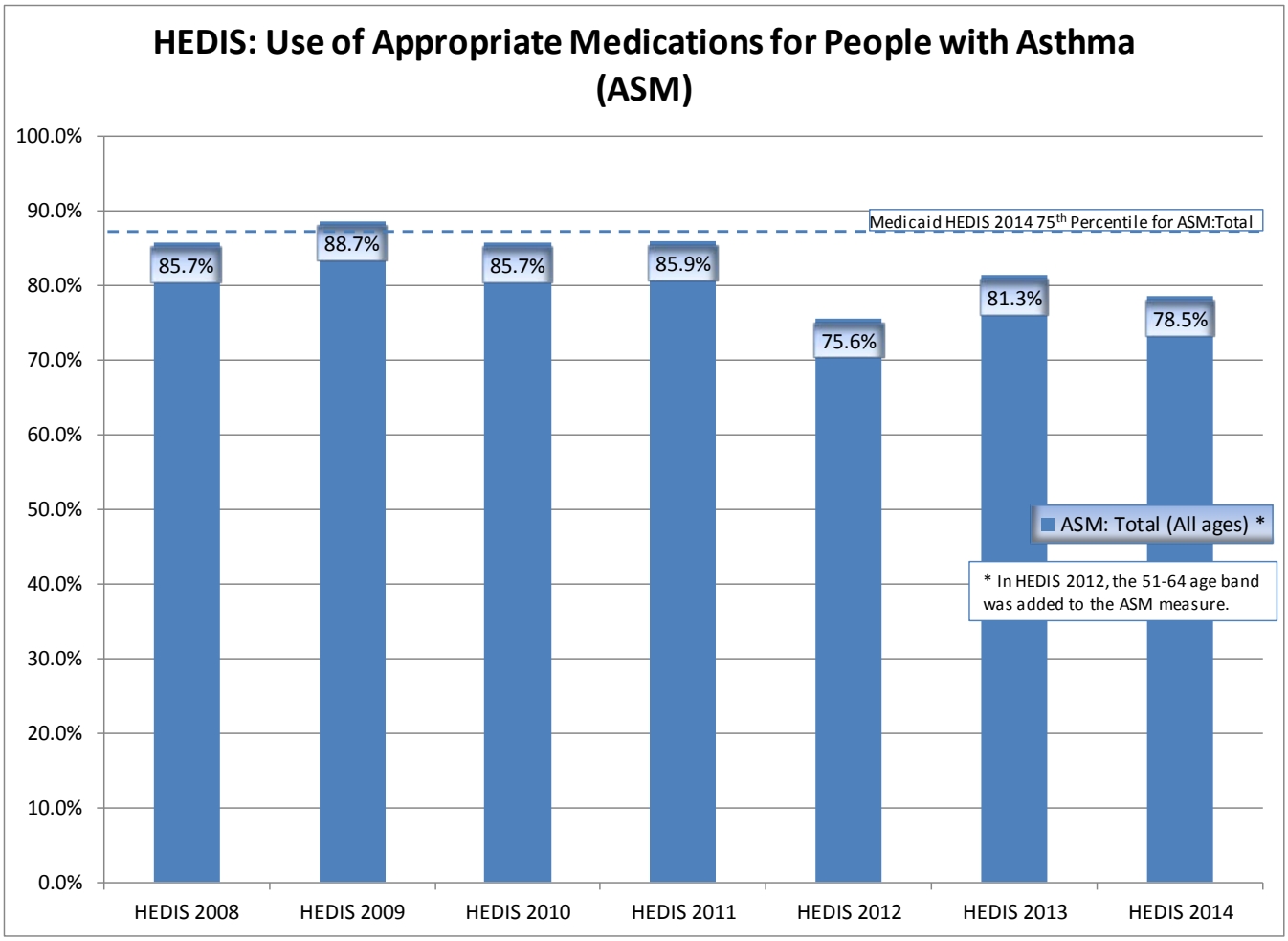
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST and QExA plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ʻOhana Health Plan, and UnitedHealthcare Community Plan. It should be noted that prior to HEDIS 2011, only the QUEST recipients are reflected in the HEDIS scores. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning in January 1 and ending on December 31 of the report year, and are due to Med-QUEST on approximately June 30 of the following year. These are sent via standard NCQA electronic file (IDSS) to Med-QUEST, and are then weight-averaged to create composite HEDIS measures for the entire Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by our External Quality Review Organization (EQRO).

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures. The measures presented below are a small sample of the complete set of HEDIS measures that are reported each year,

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from 2008 to 2014. A comparison is made to the 2014 National Medicaid Median 75th Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75th Percentile score as the target score for most of the HEDIS measures.

For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits, higher numeric scores are considered positive and lower numeric scores are considered negative; for these exception measures lower numeric scores are considered positive and higher numeric scores are considered negative.

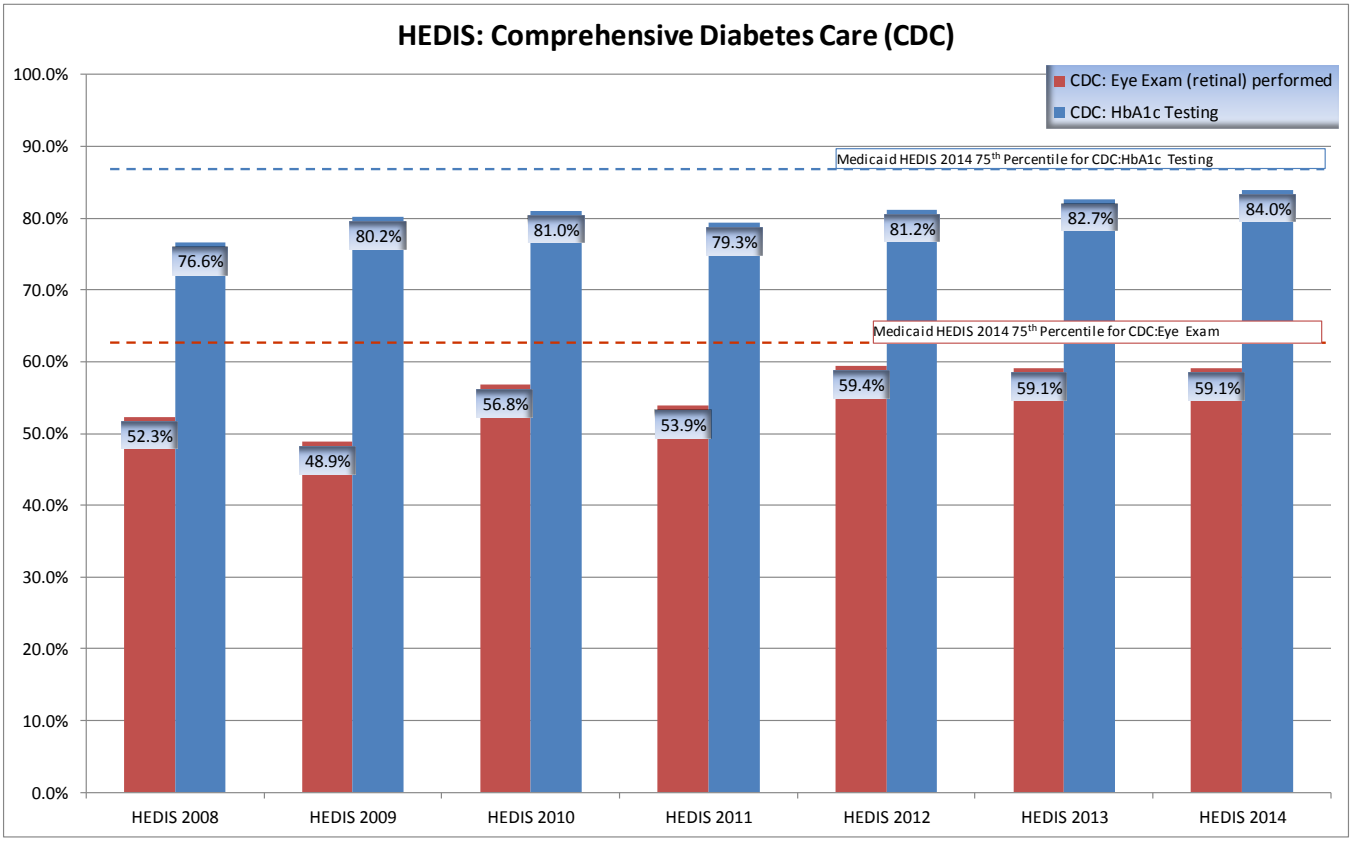


ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2014, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have substantially increased the rates in later years.

- The 2014 year's score have decreased since the marked improvement made in 2013 and is ranked second lowest overall.

- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target is higher than the previous years reported, with the exception of 2009 when its rate (88.7%) seems to have met it.



CDC – Eye Exam:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed varied between 48% and 60% from 2008 to 2014, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

- There is a flat trend (no trend) in the rates of the past three years reported. The latest year (2014) reported a rate consistent with 2012. The first two years (2008 and 2009) reported the lowest rates.

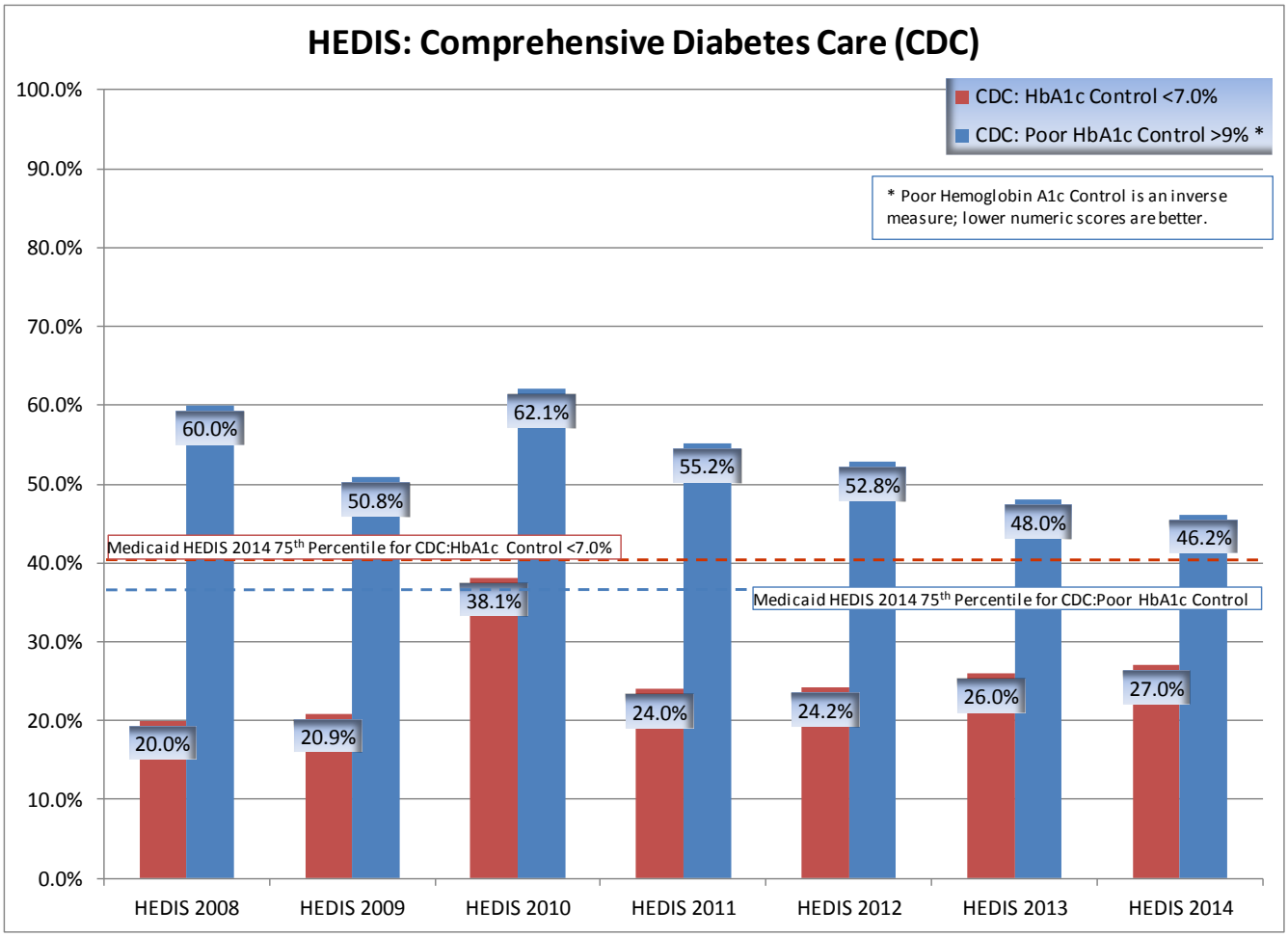
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, the target was not met.

CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 77% and 84% from 2008 to 2014, with the highest rate of 84% occurring in 2014 and the lowest rate of 76.6% occurring in 2008.

- There is a moderate uptrend in the rates of the seven years reported. The latest year (2014) reported the highest rate and the first year (2008) reported the lowest rate.

- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was above all of the years reported.



CDC – HbA1c Control <7.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under good control varied between 20% and 39% from 2008 to 2014, with the highest rate of 38.1% occurring in 2010 and the lowest rate of 20.0% occurring in 2008.

- There is a moderate uptrend in the rates of the seven years reported. The latest year (2014) reported the highest rate (except for the outlier of 38.1% in 2010), and the earliest year (2008) reported the lowest rate. In 2010, the rate of 38.1% seems like an outlier score especially when considering the six other years' scores were between 20.0% and 27%

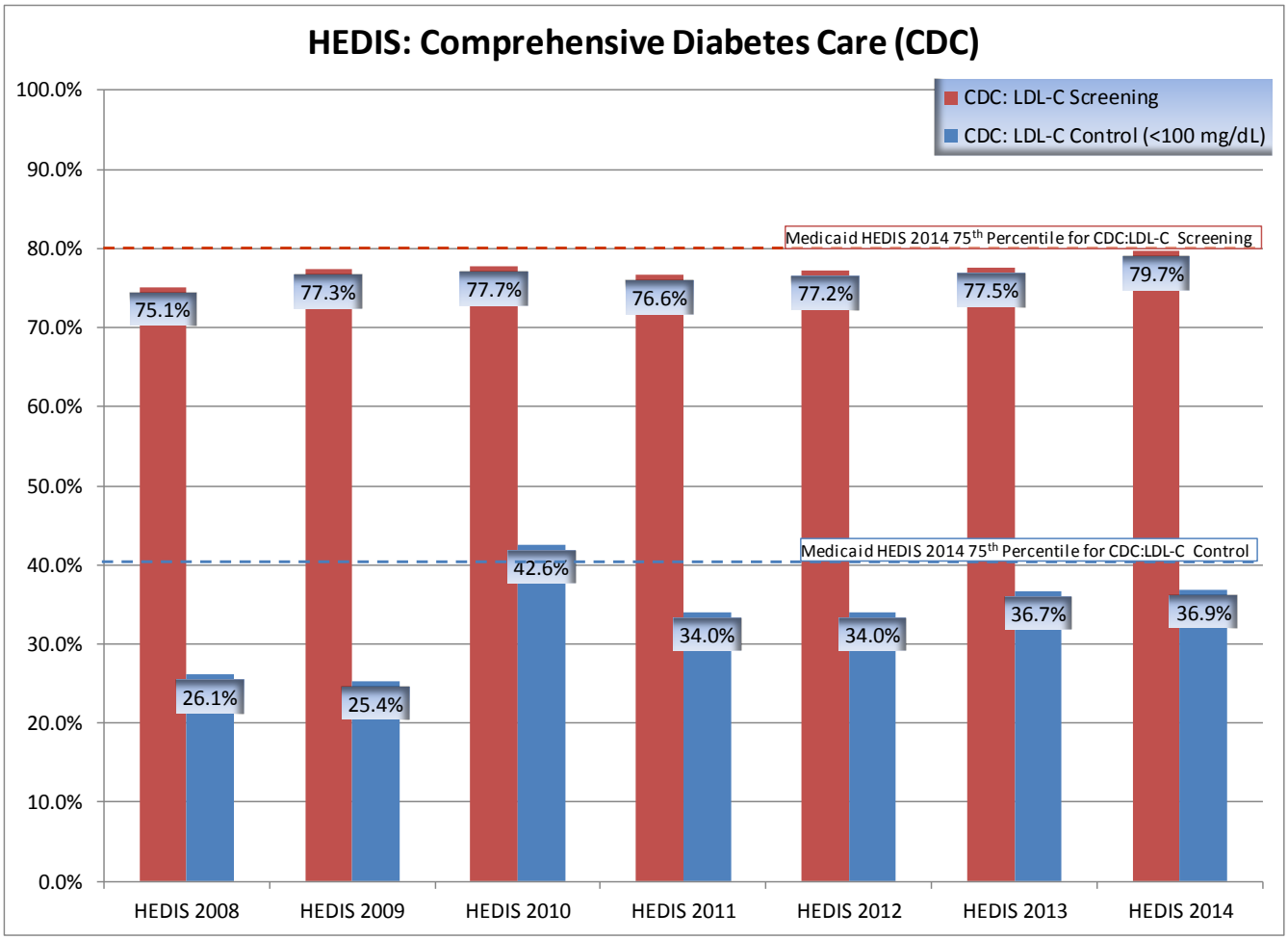
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 47% from 2008 to 2014, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 46.2% occurring in 2014. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a slight downtrend (good) to flat trend in the rates of the seven years reported. The last four years' score went from 55.2% to 52.8% to 48.0% to 46.2% with the lowest score occurring in 2014 (46.2%).

- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25th percentile of the national Medicaid population. For the 2014, this target is below (not good) all of the years reported.



CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 80% from 2008 to 2014, with the highest rate of 79.7% occurring in 2014 and the lowest rate of 75.1% occurring in 2008.

- There is a slight uptrend in the rates of the last four years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

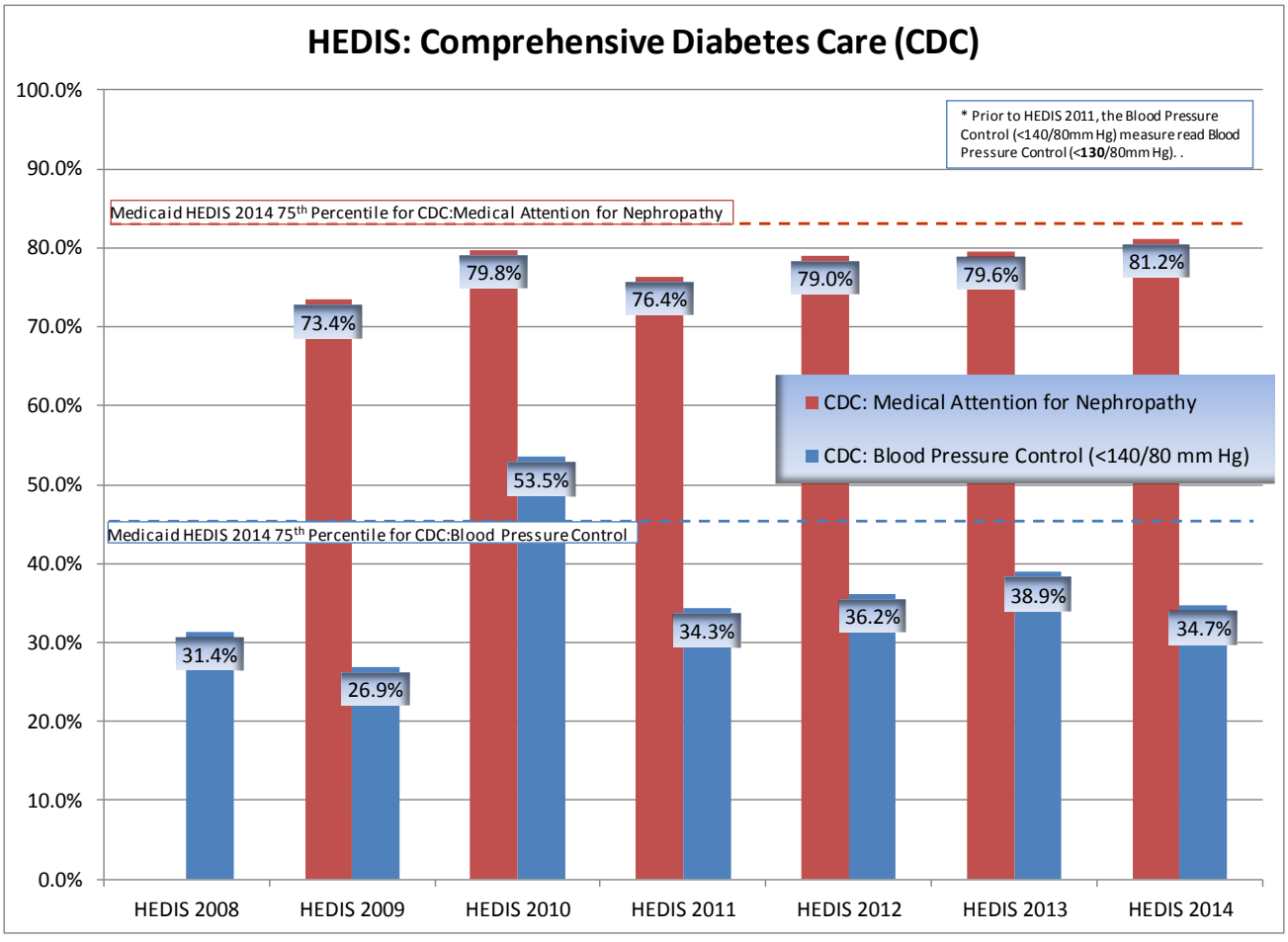
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was closely met.

CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2014, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- There is a flat trend (no trend) in the rates of the seven years reported. The last three years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2009).

- The HI Quality Strategy target percentage for the CDC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with a national averages, this target was higher than all of the years reported, except for 2010 when the rate (42.6%) seemed to have exceeded it.



CDC – Medical Attention for Nephropathy:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 82% from 2009 to 2014, with the highest rate of 81.2% occurring in 2014 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.

- There is a slight up trend in the rates of the six years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2014) had a rate (81.2%), which is an all-time high.

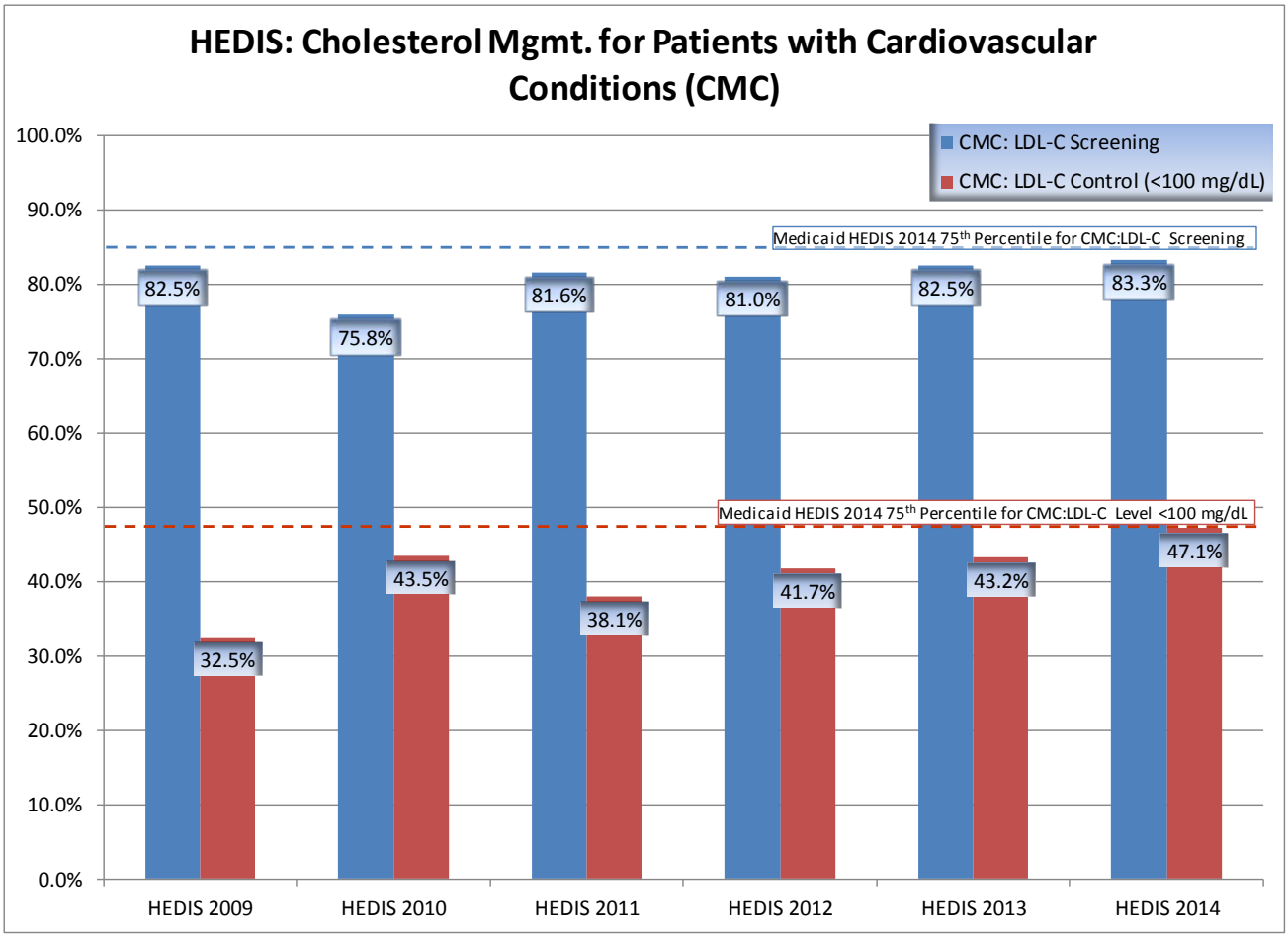
- The HI Quality Strategy target percentage for the Medical Attention for Nephropathy measure is the 75th percentile of the national Medicaid population. For the 2014, this target is higher than all of the years reported.

CDC – Blood Pressure Control (<140/80 mm Hg):

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2014, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.

- There is a slight up trend in the rates of the first six years reported; the rate in 2014 (34.7%) decreased to the previous trend in 2011 (34.3%). Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2012 (36.2%) and 2013 (38.9%).

- The HI Quality Strategy target percentage for the CDC Blood Pressure Control (<140/80 mm Hg) measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was higher than all of the years reported except for in 2010.



CMC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 84% from 2009 to 2014, with the highest rate of 83.3% occurring in 2014 and the lowest rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a slight uptrend in the rates of the last three years reported. The highest rate was reported in last year (2014), the lowest rate occurred in the second year (2010), and the remaining years' scores fell between these.

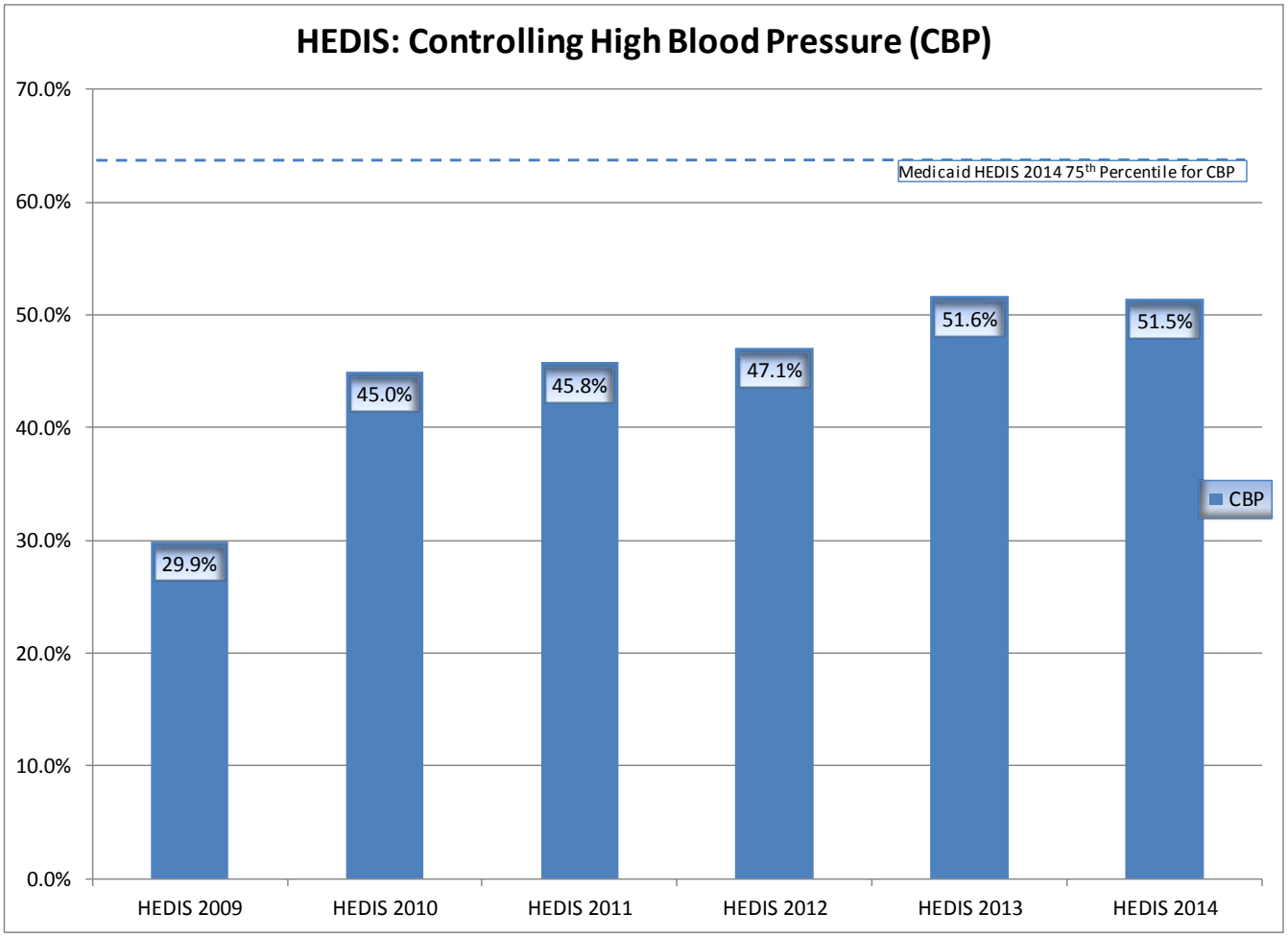
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was higher than all of the years reported.

CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 48% from 2009 to 2014, with the highest rate of 47.1% occurring in 2014 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.

- There is a clear up trend in the rates of the seven years reported. The rate in 2014 (47.1%) is the all-time highest rate.

- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, this target was nearly met in 2014.

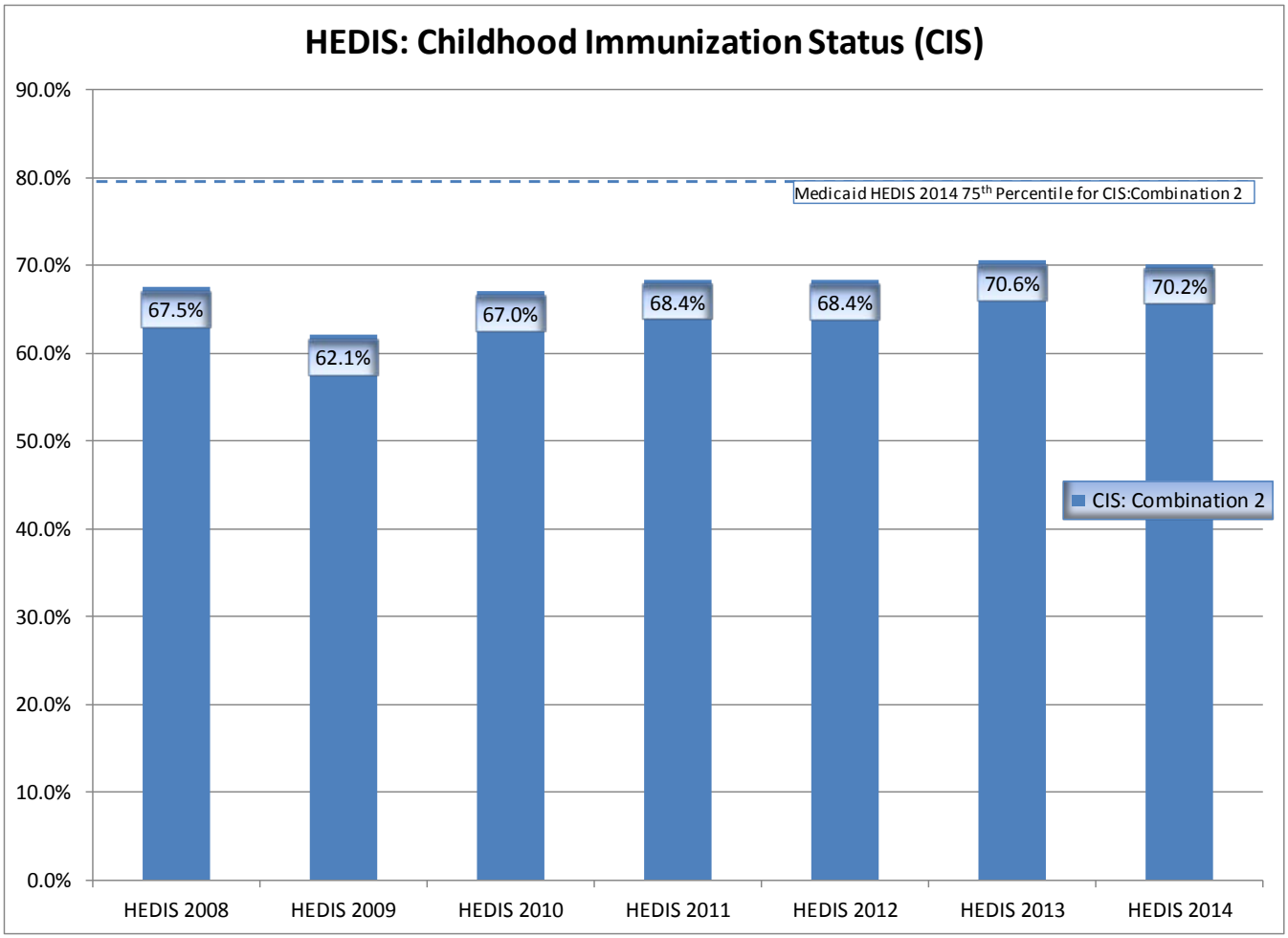


CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 52% from 2009 to 2014, with the highest rate of 51.6% occurring in 2013 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.

- There is a clear up trend in the rates of the six years reported. From 2009 thru 2013, each subsequent year's score is higher than the last. The last year's (2014) rate (51.5%) has been consistent with the previous year's (2013) rate (51.6%).

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, the target was higher than all of the years reported.

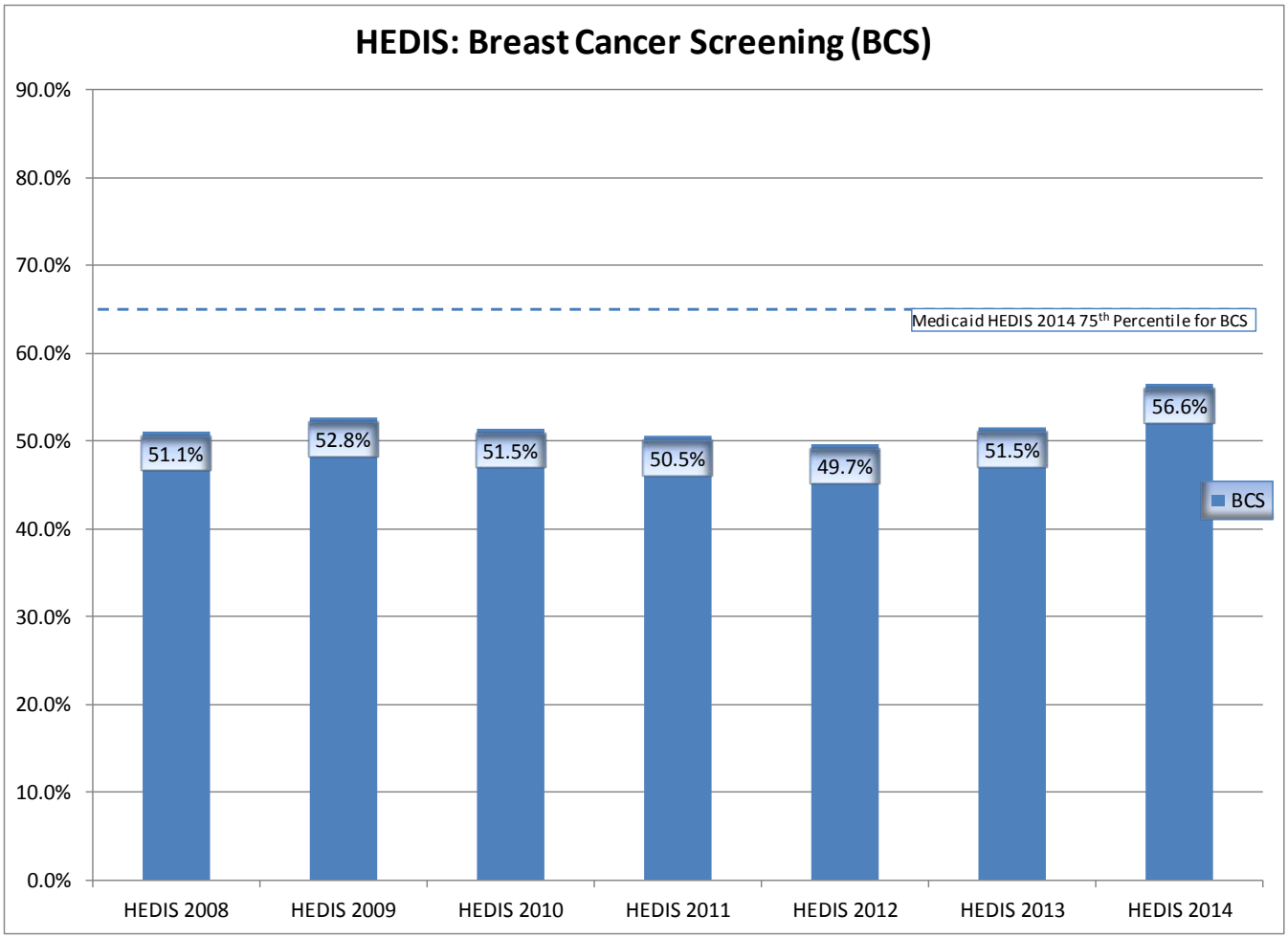


CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 71% from 2008 to 2014, with the highest rate of 70.6% occurring in 2013 and the lowest rate of 62.1% occurring in 2009.

- There is a slight up trend in the rates of the first six years reported. Excluding the 2008 rate, the rates increased from 2009 to 2013 by 3.1 percentage points with no annual decreases. In the last three years reported the rates move sideways from 68.4% to 70.6% to 70.2%.

- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, the target was higher than all of the years reported.

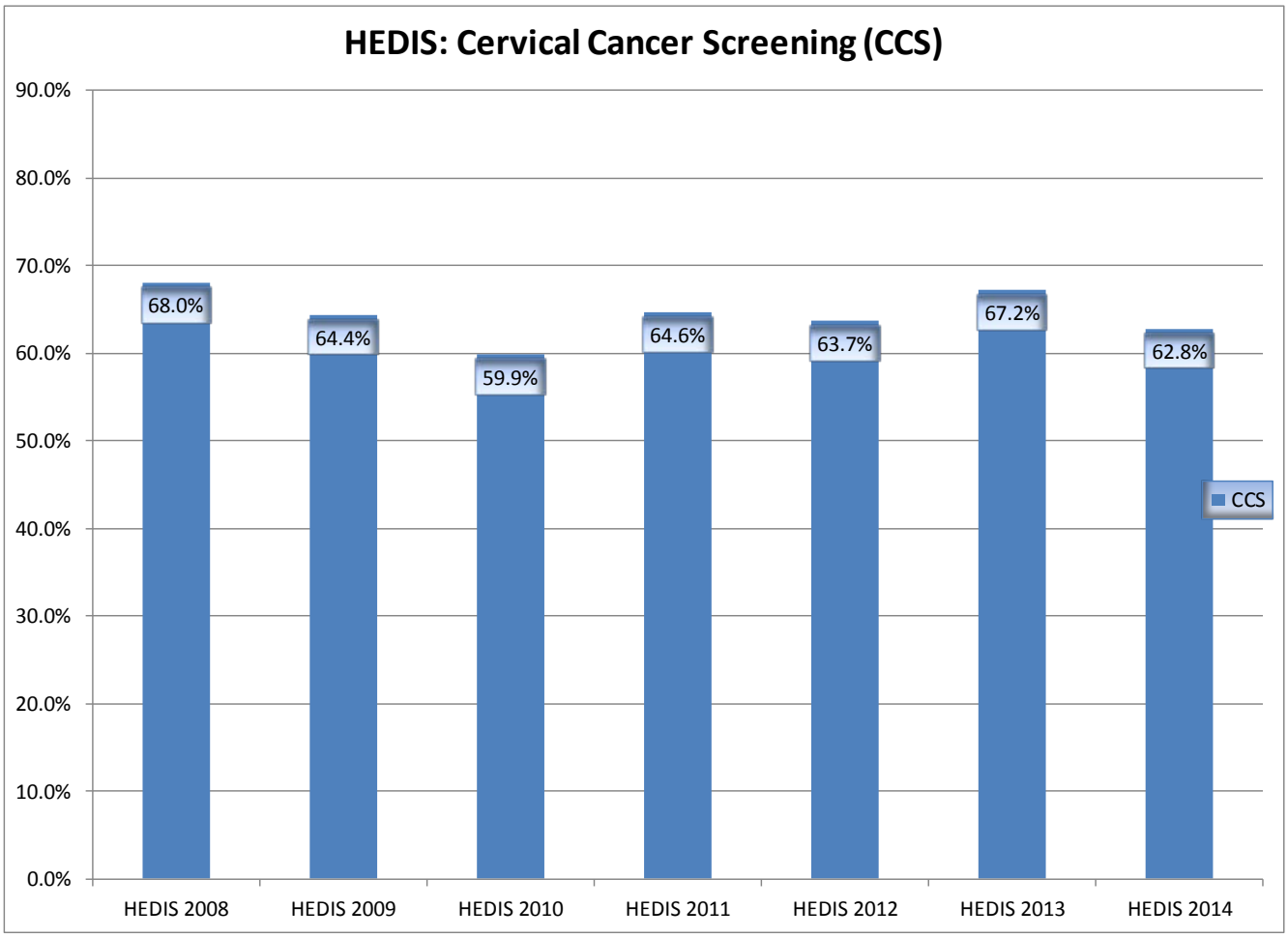


BCS:

- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 57% from 2008 to 2014, with the highest rate of 56.6% occurring in 2014 and the lowest rate of 49.7% occurring in 2012.

- There is a clear down trend in the rates for the first five years reported, however, the last two years' rates reported are trending positively (2013 with 51.5% and 2014 with 56.6%), showing strong improvement.

- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, the target was higher than all of the years reported.

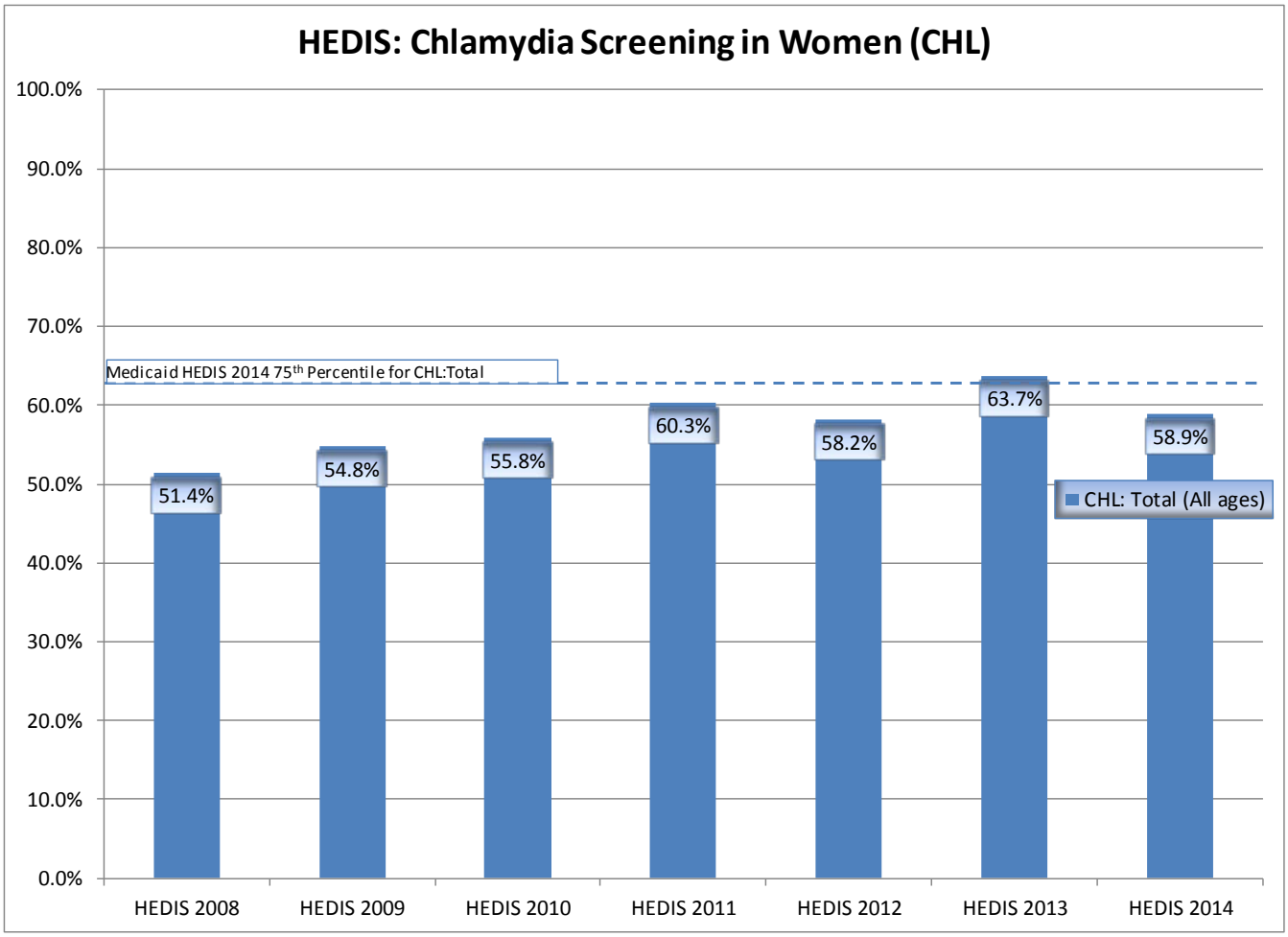


CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2014, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.

- There was a slight down trend in the rates of the first five years reported; the rate in 2013 (67.2%) increased to the previous trend in 2008 (68.0%). The rate in 2014 (62.8%) is starting to trend downward again.

- The HI Quality Strategy target percentage for the CCS measure is not currently available.

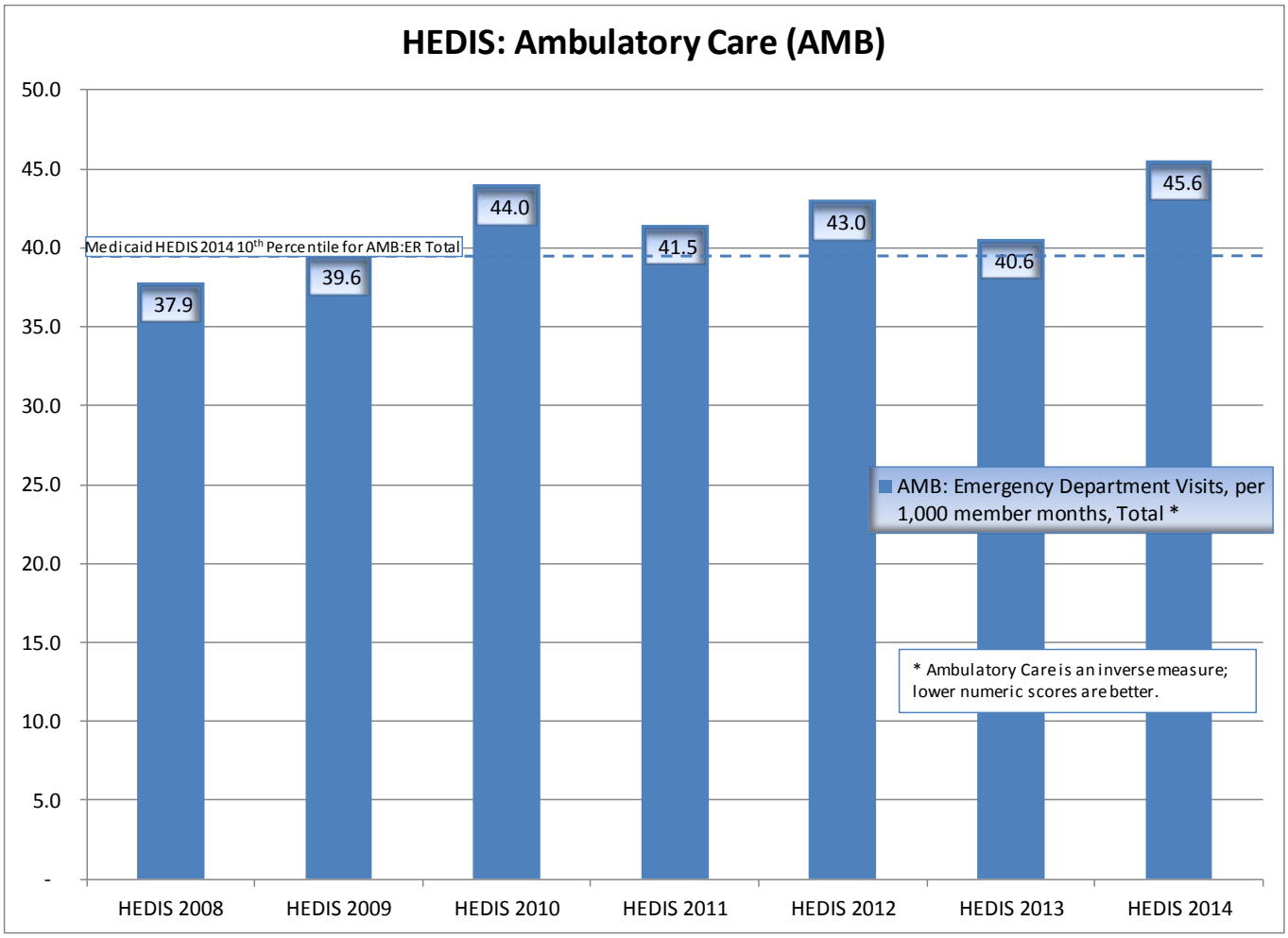


CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 64% from 2008 to 2014, with the highest rate of 63.7% occurring in 2013 and the lowest rate of 51.4% occurring in 2008.

- There is a clear up trend in the rates of the first six years reported. The lowest rate (51.4%) is in 2008 and the highest rate (63.7%) is in 2013. In the last year reported (2014) the rate (58.9%) is starting to trend downward again.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2014, the latest year with national averages, the target was not met as when HI met its quality strategy target in 2013.



AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 38.0 and 46.0 from 2008 to 2014, with the highest rate of 45.6 occurring in 2014 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a clear up trend in the rates of the seven years reported. The rate in 2014 (45.6) is at an all-time high (bad).

- The HI Quality Strategy target percentage for the AMB measure is the 10th percentile of the national Medicaid population. The target was below (bad) all of the last five years reported; For the 2014, the latest year with national averages, the target was lower (bad). Therefore, HI did not met its quality strategy goal for ambulatory care.

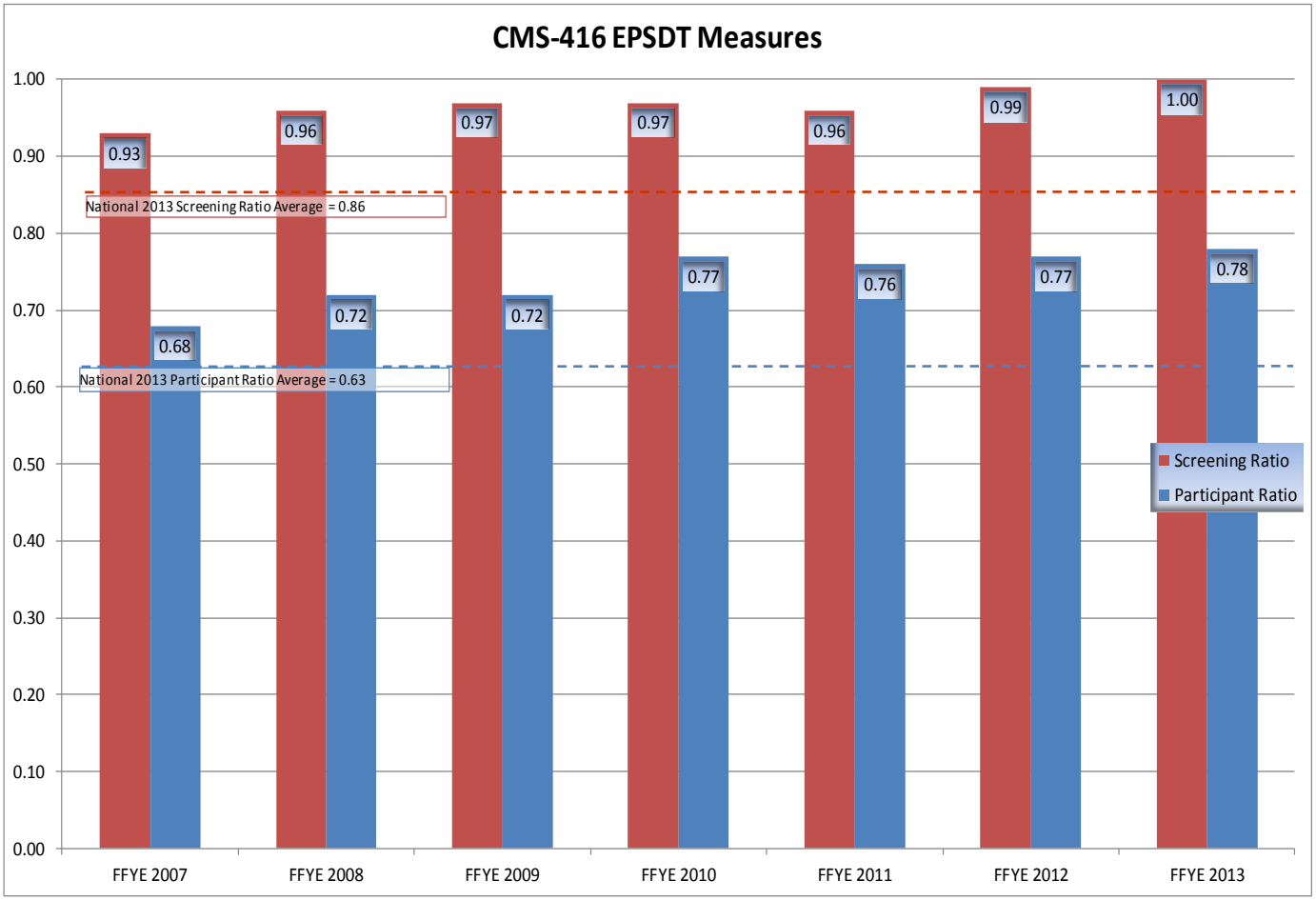
EPSDT Measures

The EPSDT measures are included in this report to measure the degree of comprehensive and preventive child healthcare for individuals under the age of 21.

The EPSDT measures are based on self-reported EPSDT reports received from the five individual plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan and UnitedHealthcare Community Plan. The scores from these individual plan reports are then weight-averaged to calculate Hawaii composite scores. All five plans create custom queries to calculate their scores, and all of the EPSDT measures are reported in each year. The format and method of calculation for the various EPSDT measures reported by the plans is no different from the national standard CMS-416 EPSDT format, aside from small differences in the periodicity of visits by state. Audits on how the plans calculate and report their EPSDT scores are not currently conducted; future health plan audits on the EPSDT calculation and reporting are being considered. EPSDT reports from the plans are based on the federal fiscal year, a twelve month period beginning in October 1 and ending on September 30 of the report year, and are due to Med-QUEST on the last day of February in the year following the report year. The measures presented below are a small sample of the complete set of EPSDT measures that are reported each year.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Scores are reported for each year from 2007 to 2013. EPSDT is measured on a Federal Fiscal Year, therefore, the most recent results for this report are FFY13. A comparison is made to the National Medicaid EPSDT Average score – the 50^{th} percentile – to bring perspective to where we stand on a national level.

For all of the EPSDT measures, higher numeric scores are considered positive and lower numeric scores are considered negative.



EPSDT – Screening Ratio:

- The statewide Medicaid screening ratio from the EPSDT report varied between 0.93 and 1.00 from 2007 to 2013, with the highest rate of 1.00 occurring in 2013 and the lowest rate of 0.93 occurring in 2007.

- There is a clear up trend in the rates of the seven years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 1.00 was reported in the last year reported (2013), with a mostly steady uptrend in between.

- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2013, the latest reported year, the national average is lower than all of the years reported.

EPSDT – Participant Ratio:

- The statewide Medicaid participant ratio from the EPSDT report varied between a high of 0.78 occurring in 2013 and the lowest rate of 0.68 occurring in 2007.

- There is a clear up trend in the rates of the seven years reported. Each year's score was at least equal to, and more often greater than, the previous year's score, ending in a high of 0.78 in 2013.

- The MQD quality strategy has no benchmark for the EPSDT Participant Ratio. For comparison purposes in 2013, the latest reported year, the national average is lower than all of the years reported.

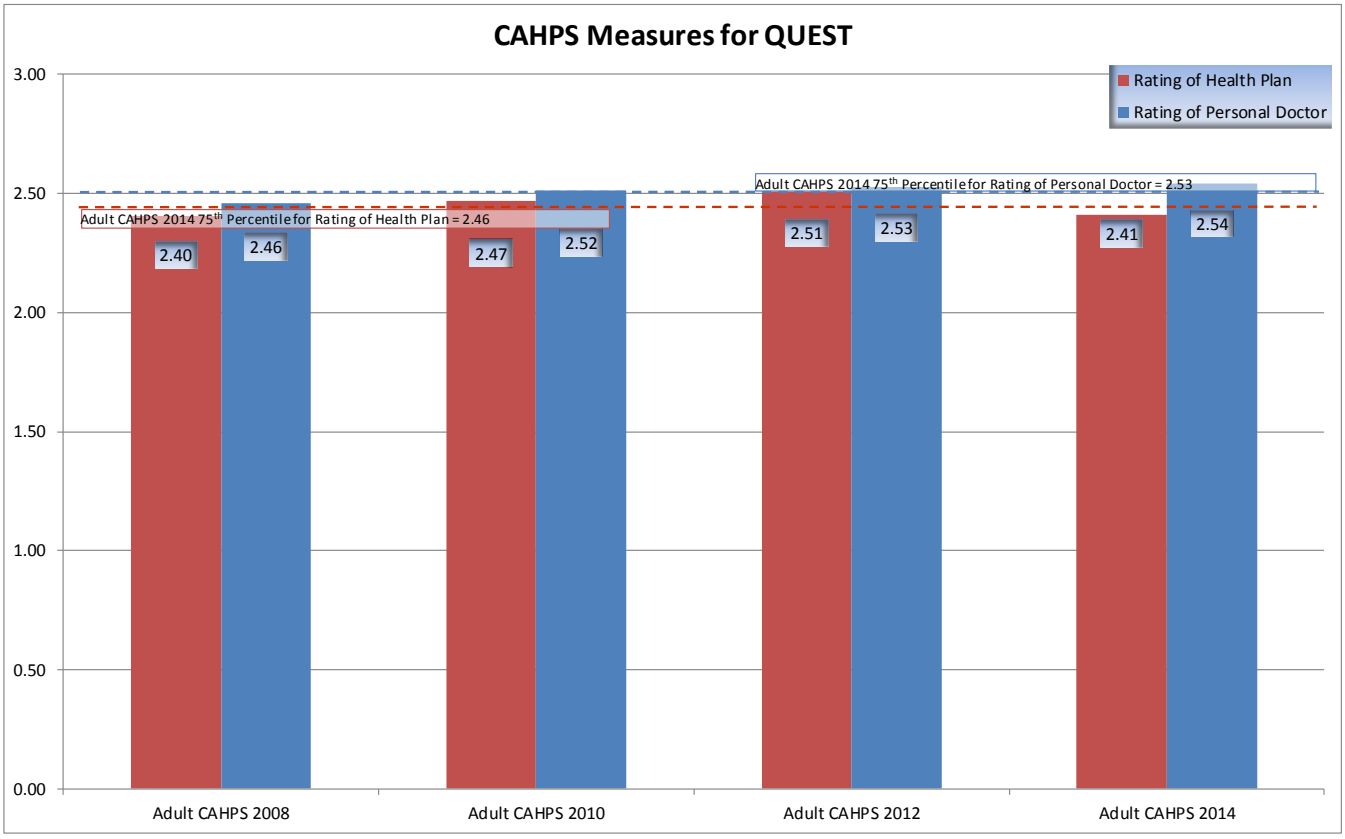
CAHPS Measures

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 45% in 2011 and 38% in both 2012 and 2013. In 2014, it was 39.9% (35.2% for QUEST and 52.1% for QExA) overall. The "question summary rates" are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010, 2012, and 2014 and the Child Medicaid survey was done in 2009, 2011, and 2013. Only the 2014 results (from the Adult Medicaid surveys) are reported here. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan as well as program (QUEST vs. QExA). Since the QExA program was begun in February 2009, there are a limited number of years of CAHPS data for QExA. This report presents the rates of the QUEST population and the QExA population in separate charts. Going forward and as required by the State of Hawaii, these surveys will continue to be done annually, with the Child and Adult surveys being done in *alternating* years. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows. A comparison is made to the National Medicaid Child CAHPS 2014 75th percentile score to bring perspective to where we score on a national level. The National Medicaid 75th percentile score will be the target score for all of the CAHPS measures, as is specified in our Quality Strategy.

For the CAHPS measures, higher numeric scores are considered positive and lower numeric scores are considered negative.



CAHPS for QUEST – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the Adult QUEST population varied between a high rate of 2.51 occurring in 2012 and the lowest rate of 2.40 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is a clear up trend in the rates of the first three survey results reported. The rates moved from 2.40 to 2.47 to 2.51. However, recently, the 2014 rate (2.41) is starting to trend downward.

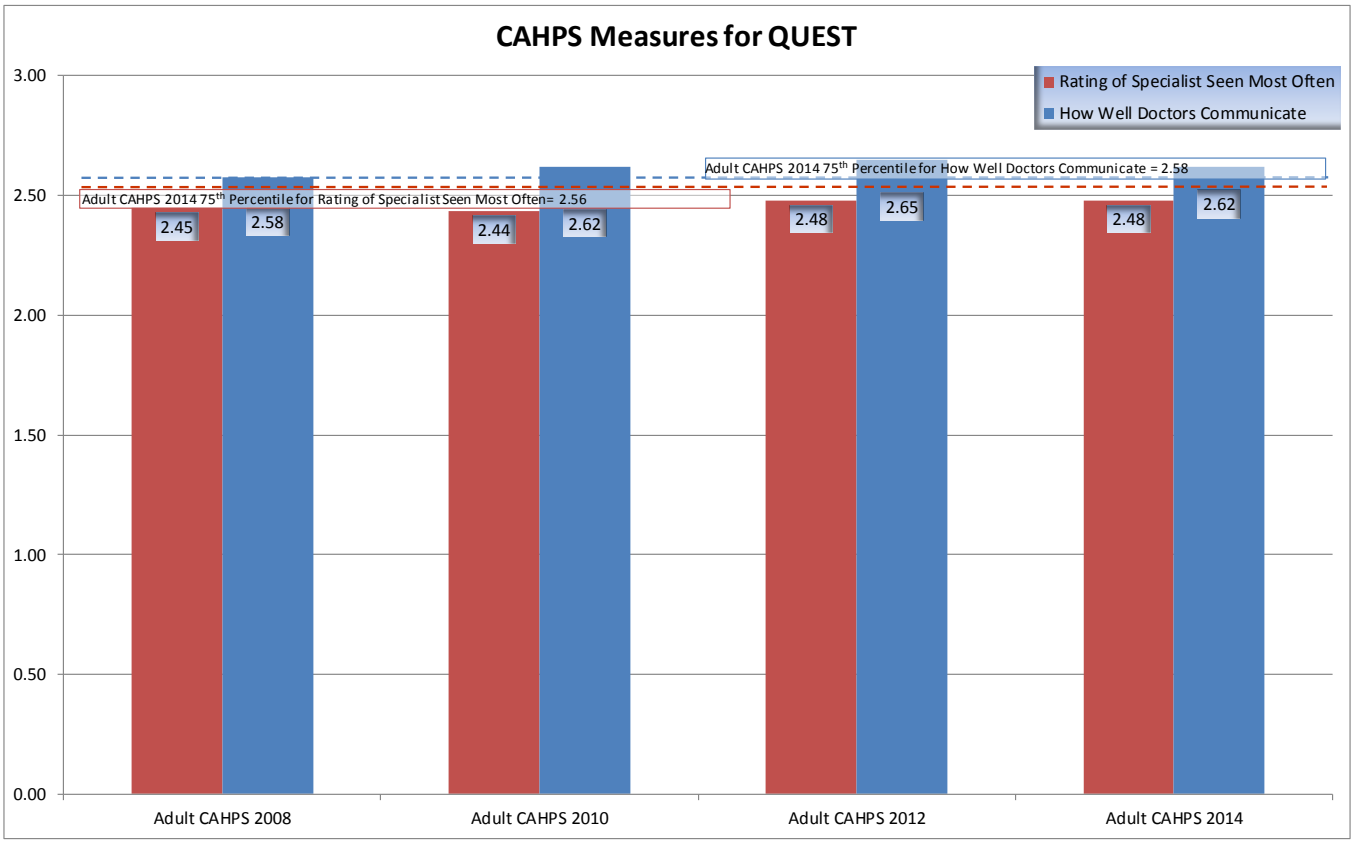
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For 2014, the latest year with national averages, this target was 2.46 and not exceeded by the 2.41 rate reported in 2014.

CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.54 occurring in 2014 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is a clear up trend in the rates for the years reported for the Adult surveys. For the Adult years, the rates increased steadily from 2.46 to 2.54.

- The HI Quality Strategy target percentage for the CAHPS, Rating of Personal Doctor, is the 75th percentile of the national Medicaid population. For 2014, the latest year with national averages, this target was 2.53, which was met the past two years (2.53 in 2013 and 2.54 in 2014).



CAHPS for QUEST – Rating of Specialist Seen Most Often:

- The statewide CAHPS – Rating of Specialist Seen Most Often for the QUEST population varied between a high rate of 2.48 occurring in 2012 and 2014, and the lowest rate of 2.44 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is no clear trend in the rates of the four years reported. For the Adult years, the rates moved slightly up from 2.45 to 2.44 to 2.48 and remained at 2.48.

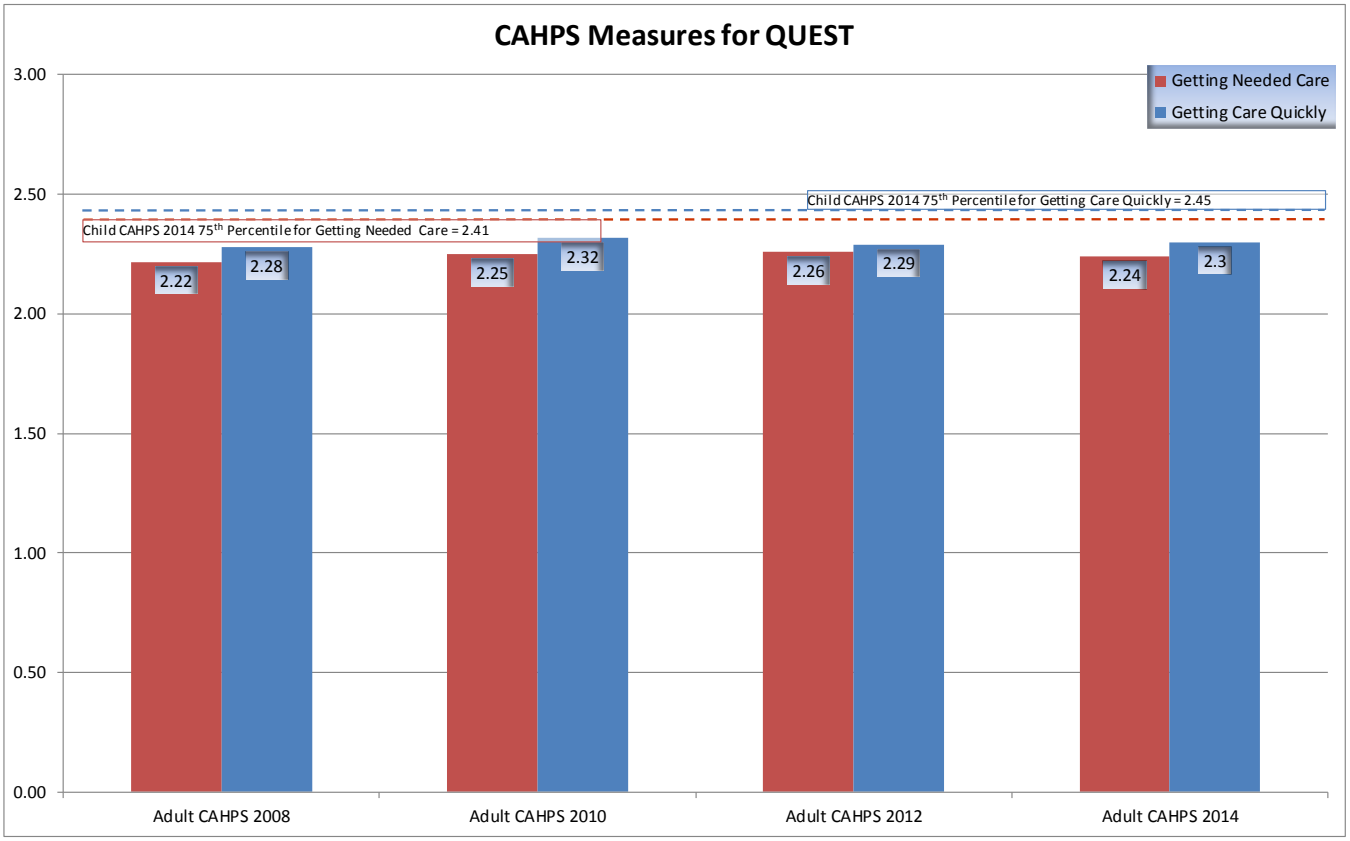
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For 2014, the latest year with national averages, this target was 2.56 that was higher than all of the reported years.

CAHPS for QUEST – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.65 occurring in 2012 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is a clear up trend in the rates of the first three Adult surveys reported. For the Adult years, the rates move from 2.58 to 2.62 to 2.65. Then, in 2014, the rates had a slight downtrend back to 2.62.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For 2014, the latest year with national averages, this target was 2.58, which was met in all the years reported.



CAHPS for QUEST – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QUEST population varied between a high rate of 2.26 occurring in 2012 and the lowest rate of 2.22 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is no clear trend in the rates of the first three Adult surveys reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26 then decreased to 2.24 in 2014.

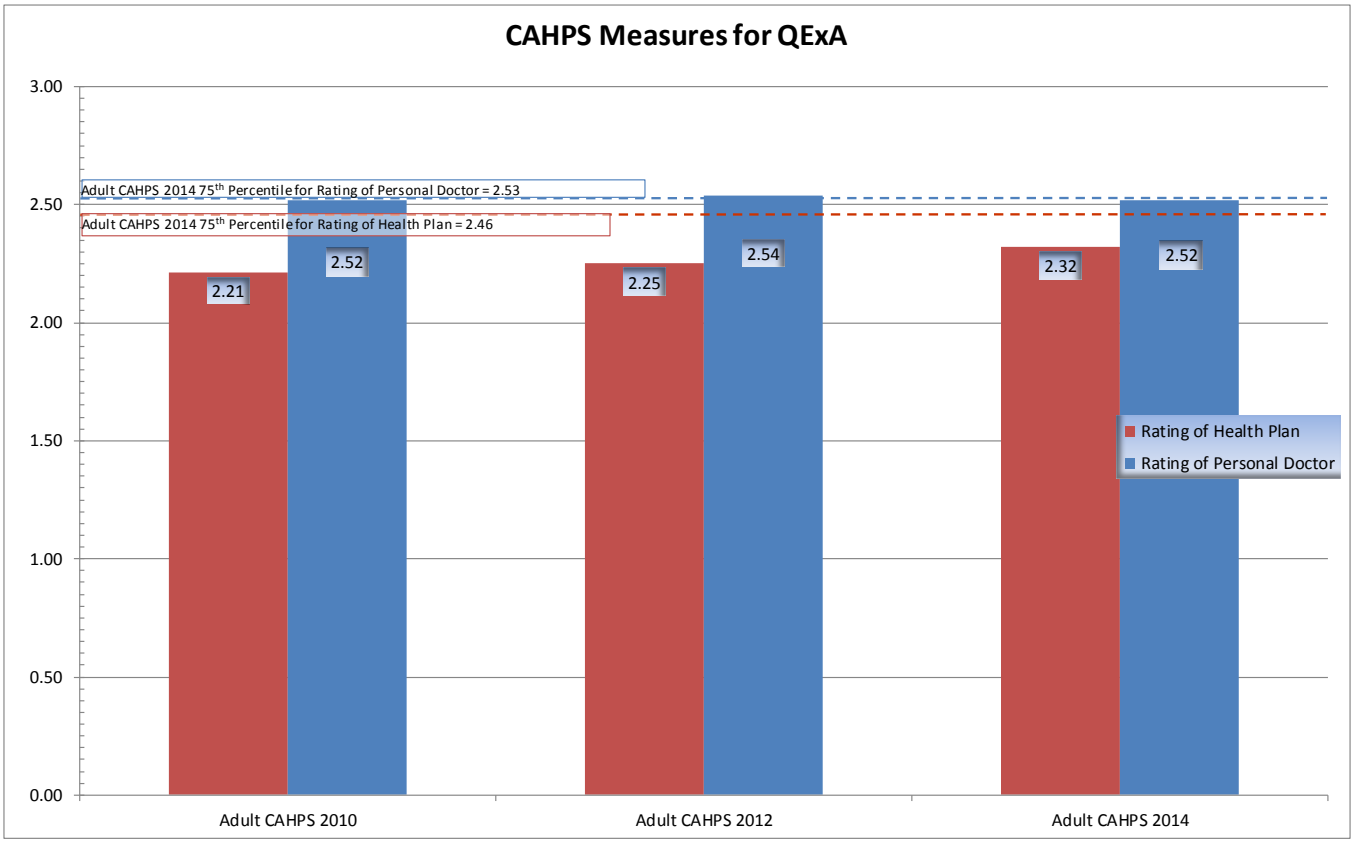
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For 2014, the latest year with national averages, this target was 2.41 which is higher than all of the reported years.

CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.32 occurring in 2010 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is no clear trend in the rates of the four years reported for the Adult surveys. For the Adult years, the rates moved sideways from 2.28 to 2.32 to 2.29 to 2.3.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly, is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.45 that was higher than all of the reported years.



CAHPS for QExA – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.32 occurring in 2014 and the lowest rate of 2.21 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published. Also, note that the QExA program began in February 2009, which limits the number of data points.

- There is a clear uptrend in the rates of the three years reported. The low point in 2010 (2.21) was the first data point for the Adult population. The data for the Adult population has increased from 2.21 (2010) to 2.25 (2012) to 2.32 (2014).

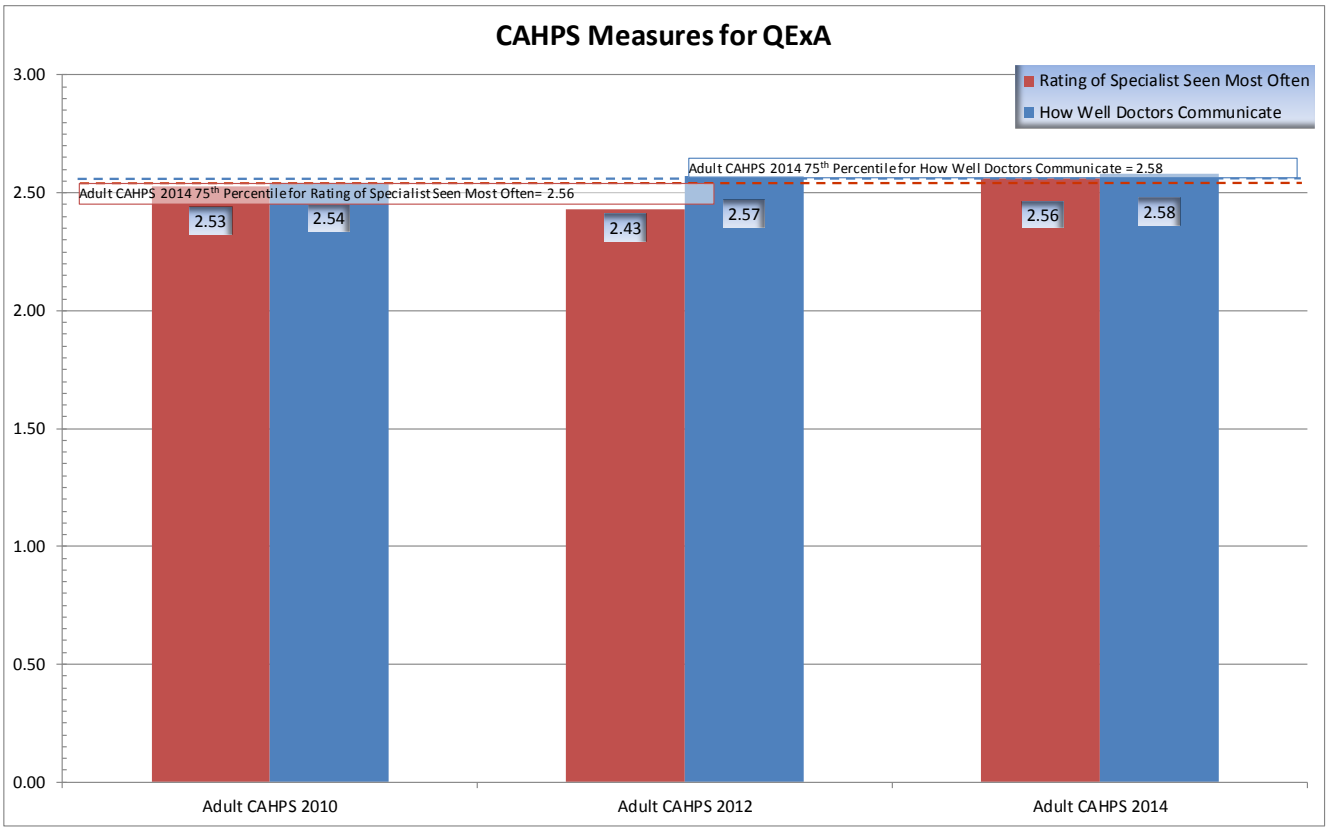
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2014 year, this target was 2.53 that was better than all reported rates.

CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS Rating of Personal Doctor for the QExA population varied between a high rate of 2.54 occurring in 2012 and a low rate of 2.52 occurring in 2010 and 2014. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There is no clear trend in the rates of the three years reported for the Adult surveys. The three years lie within a 0.02 point window.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.53 which was higher than 2010 and 2014 reported years' rates (2.52) but lower than the 2012 rate (2.54).



CAHPS for QExA – Rating of Specialist Seen Most Often:

- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.56 occurring in 2014 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- The trend in the past year (2014) has increased, higher than the rate (2.53), when the survey commenced in 2010.

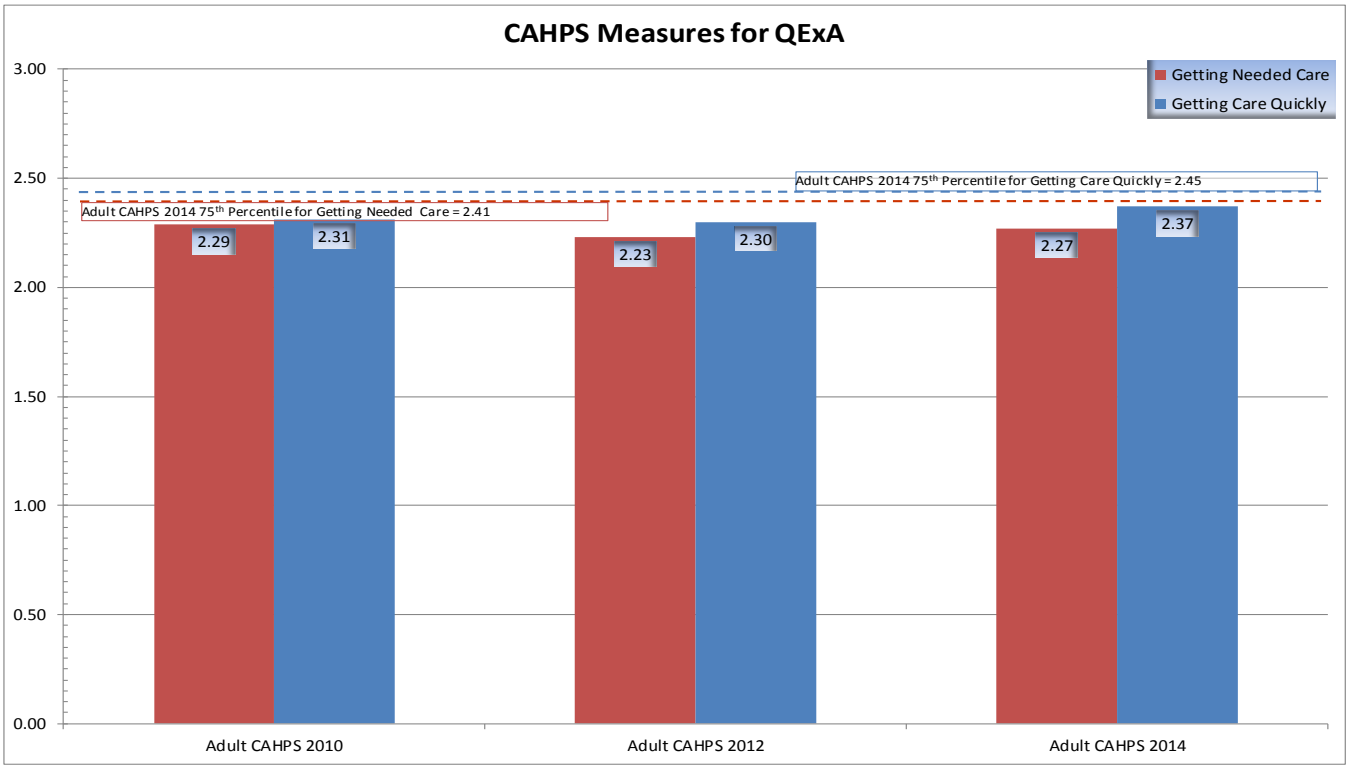
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.56 that was achieved in 2014.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.58 occurring in 2014 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- The trend in the three years reported for the Adult survey is slightly increased. The Adult score moves from 2.54 to 2.57 to 2.58 from 2010 to 2014.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.58 that was met in 2014.



CAHPS for QExA – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QExA population varied between a high rate of 2.29 occurring in 2010 and the lowest rate of 2.23 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- There 2014 rate (2.27) is trending positively towards the highest rate of 2.29 from 2010 when the Adult survey commenced.

- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.41 that is above each of the reported years.

CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.37 occurring in 2014 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child. The results for the Child surveys were previously published.

- The Adult rates remained consistent from 2010 to 2012 but trending positively in 2014 with an all-time high of 2.37.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2014 year, the latest year with national averages, this target was 2.45 that is higher than all of the reported year.

Med-QUEST Internal Measures

The Med-QUEST internal measures are included in this report to measure the financial aspects of the Hawaii Med-QUEST program. How is money being spent, and on how many and what type of recipients, is the focus of these measures.

The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is an alternate service delivery model to traditional nursing home institutions. Instead of nursing home clients staying in an institution, they are out in the community and interacting. HCBS facilitate the continued social and mental stability of the client, as well as reduce the cost of serving this population. The average monthly $ PMPM difference between a HCBS client and an institutional client was $5,375 in SFY14. We look at both the increase in HCBS % of the total nursing home LOC population as well as the MQD's cumulative annual dollars saving from this increase in HCBS %. The cumulative dollar savings is calculated by determining taking the difference between the current year's HCBS % and the 2009 HCBS%, multiplying it by the total nursing home LOC population to get a monthly savings figure, and then multiplying it by twelve to get an annual savings figure.

The member month measure used is a sum of member months, and will consist of entire populations based on reports run at the end of each month. The capitation payment file is a detail of all capitation payments made to each plan, and is the source of member month data. This file has enrollments for retro payments reflected in the month that payment was made. Initial months are paid pro-rated daily amounts based on the start date. Termination always occurs at the end of the month, except for retro termination for disability or death.

Recent Initiatives on Measures

The following section will discuss initiatives that the health plans have started and also continued to improve the rates of the various measures discussed above.

HEDIS Initiatives

Use of Appropriate Medications for People with Asthma (ASM) Initiatives

- For one health plan, members with chronic conditions such as congestive heart failure, diabetes, and asthma were enrolled in and informed through a Disease Management Program.
- Providers were educated on HEDIS requirements and clinical practice guidelines semi-annually.
- Clinical Practice Guidelines are available web site, in the provider newsletter and the Provider Administrative Guide.
- Conferences, visits, reports and community programs were informative as well.

Comprehensive Diabetes Care (CDC) Initiatives

One health plan conducts causal/barrier analysis and evaluation of the efficacy of its interventions regularly.

- It updates interventions in response to identified barriers. In the *Diabetes Care* PIP, it changed its Pay for Quality measures and updated its reimbursement rate for diabetes education, based on an evaluation of specific HEDIS measure performance.
- It regularly conducts drill-down analyses during the review of interventions. For example, in the *Diabetes* PIP it analyzed comorbidities as a condition that may influence better control of HbA1c and found that members with diabetes and mental conditions had poorer control of their HbA1c. The intervention was adjusted to include coordination between medical and behavioral health.

The plan encourages flexibility and creativity at the provider level to address specific clinical and population needs. An example is the Advanced Hospital Care (AHC) program. The AHC incentivizes providers to lower admission rates while providing information about readmissions and other indicators.

- Specific to the AHC program, it sponsors collaboratives. For diabetes, as well as other clinical needs, it works with provider organizations to hold regular collaborative meetings to share best practices in clinical care and service.

In October 2013, another health plan updated the diabetes-related clinical practice guidelines, and informed its members and providers.

Another health plan reported that diabetes (HbA1c Control) has been a renewed priority in the region for 2013-2014. In addition to continuing its current processes, they trialed some new processes. Both are described as follows:

- Panel Support Tool (PST)- Tool used consistently by the PCP team to flag needed prevention and chronic disease gaps for each member at the point of care. It allows the PCP team to outreach to members who are not coming in to the clinic.
- Diabetes Education Classes are still available
- Electronic medical record system- Manages lab results for diabetes members.

- Patient Support Services (PSS) continues to be the central population management support for the PCP team for diabetes and cardiovascular disease members.
- Automated batch ordering of labs every six months continues for members with diabetes. Automated recorded reminders are used for members with overdue labs.
- To increase medication compliance, PSS staff members strive to ensure that Medicaid diabetes members receive a three-month supply of medications.
- A new process to address poor HbA1c control of >9 was begun in mid-2012. More recently, this effort has expanded to proactively reach members with A1c control of >8. Dedicated nursing and pharmacy PSS staff members assist PCP teams serving diabetes members with poorly controlled HbA1c.

Other Implementations By The Health Plans:

- New performance improvement projects (PIPs) in CY 2013, one of them a *Diabetes Mellitus* PIP. For this PIP, the plan implemented a cross-departmental PIP work group.
- The Study Indicator 1 title in the *Diabetes Care* PIP was clarified to indicate that the most recent HbA1c Test is referenced to ensure numerator compliance.
- One health plan allows members to self-refer for many specialties, including behavioral health. In 2013, another service was added to the list to allow members direct access to additional specialists.
- Service coordinators (SCs) performed outreach calls to members with diabetes care gaps. They educated members about the importance of diabetes management and reminded or assisted with scheduling appointments with the members' physicians.
- As a result of close collaboration between the health plan and its clinical partners, the plan was able to identify areas of opportunity that could be streamlined to remove unnecessary burden to the provider and to improve timely access to care and service for the member. An example is the change to the prior approval process to cover diabetic supplies for pregnant women with impaired glucose tolerance.
- Drill-down analysis of diabetic care gaps by city, gender, age, ethnicity/race, and PCP was completed in 2013 and compared to 2012. The analysis was mostly helpful in identifying the age group and cities on which to focus interventions.

Cholesterol Management for Patients with Cardiovascular Conditions (CMC) and Controlling High Blood Pressure (CBP) Initiatives

One health plan carried out the following to work on improving the *CDC* measures, especially the sub measures [*Blood Pressure <140/80* (to be retired in HEDIS 2015), *Blood Pressure <140/90* (to be moved to *Controlling Blood Pressure* measure in HEDIS 2015) and *HbA1c Testing*] below the 75th percentile:

- Instituted a new process using resources and tools from OPTUM (a health plan company) for medical record reviews (MRR) and implemented more frequent and more effective oversight by the health plan during the HEDIS season. Quality department staff members were also added. The health plan also monitors administrative data completeness quarterly.
- Disease Management Program – A source of information for members and providers.
- In 2013, community events were held and they distributed literacy promoting health education, health literacy, and preventive health care which included Taking Care of Your Heart, Healthy Weight, Healthy Life, and Preventive Health Care and Screenings

- PST is the tool used to indicate labs that are due (e.g., A1c, LDL) and recommend adjustments in medications for labs that are not at goal (e.g., adjustment of orals or addition of insulin for A1c or LDL labs that are not at goal).
- The PSS is also used as is the central population management support for the PCP team for cardiovascular disease members. This team of nurses and pharmacists helps contact members due for labs and/or medication pick-up and assists PCP teams with titrating medications to bring members to goal.
- Automated batch ordering of labs every six months continues for members with diabetes. Automated recorded reminders are used for members with overdue labs.
- Within one health plan's *Diabetes LDL* PIP, to provide the additional assistance to the PCP team, PSS has been focusing outreach toward Medicaid diabetes members, regardless of whether or not the member has been referred to PSS. In addition to the reminder calls about labs, PSS also assists in titrating medications to get A1c and LDL levels to goal.

Childhood Immunization Status (CIS) Initiatives

One health plan has initiated a strategy for 2014 to improve completeness of claims/encounter and laboratory data by adding supplemental databases from electronic health record (EHR) files. EHR files will contain more complete data on laboratory results, immunizations, and other elements not included on claims. It was proactive in submitting supplemental databases inputted for laboratory results, childhood immunizations, and chlamydia screening and included an EHR file from its largest provider.

In addition, another health plan has ongoing disease management programs that remind members of preventive screenings and have several outreach programs to educate members on chronic condition management and preventive care he following lists the various outreach programs such as the Centralized Telephonic Outreach program that assists with scheduling appointments with their physicians.

To facilitate better access, another health plan has implemented its Patient-Centered Medical Home (PCMH) model focusing on open access. It recommended that providers conduct pre-visit planning to ensure that members have adequate time for their needs. For example, during a pre-visit planning session, a member identified as requiring an EPSDT visit would be scheduled for a 30–45 minute time slot. This allows for a thorough visit with time to administer immunizations and perform diagnostic tests.

Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), & Chlamydia Screening in Women (CHL) Initiatives

Outreach To Members:

- Another plan continued to be an active partner in the "a hui for WE" (Wellness Events) movement which provided actionable information for individuals in an effort to motivate them to work and focus on better health. It also continued its partnerships with the Women's Health Center at The Queen's Medical Center.
- HEDIS toolkits, which included a Personal Care Preventive Care Checklist for providers, were distributed during quality-focused provider visits. Providers were encouraged to use this checklist to help them identify other screening, tests, vaccines, or assessments needed when a patient comes in for an office visit.
- Ongoing disease management programs and periodicity letters remind members of preventive screenings

- Service coordinators (SCs) performed calls to members with chlamydia care gaps. They educated members about the importance of chlamydia screenings and reminded or assisted with scheduling appointments with the members' physicians. The service coordinators and case managers also accessed care gaps via EMMA (a clinical electronic medical record) and addressed them with members when they completed annual health and functional stats assessments.

For one health plan, network PCPs do not have to ask for permission to refer a member to a network specialist or provider. A PCP may simply call and/or fax a referral directly to the network specialist or provider for services. Members may self-refer for women's health and family planning services.

Ambulatory Care (AMB) Initiatives

Outreach To Members To Decrease Inappropriate Emergency Room (ER) Utilization:

In review of the top diagnoses for ER visits/1000 in 2013, one plan observed that the majority of ER visits were related not to particular diseases, but to symptom management. In February 2014, the plan pulled (by diagnosis) the top 20 members over utilizing the ER. These members were discussed at the plan's Hospital Utilization Review and Readmission Team (HURRT) meetings. It was noted that many of these members had been designated "unable to contact." A few members were contacted and then plans were developed to educate them about going to their PCP or psychiatrist for some less urgent issues. Also, the possibility of using the Nurse Advice Line and/or Urgent Care centers was reinforced.

For those members still unable to be contacted and with no other outreach avenues despite intense review of their claims, authorizations, and documents, the plan highlighted the member as a "member alert" in its electronic system. If such a member is admitted or if the ER calls the health plan, the plan will assign a service coordinator to go to the facility to perform a health and functional assessment and provide education/training on alternatives to using the ER. In addition, the service coordination staff members receive a report of high ER utilizers at least quarterly in order to identify members who may need assistance with alternate services. As a result, the plan has observed decreases in ER utilization and readmission rates for those members presented to the HURRT.

In 2014, a health plan partnered with Home Outreach Program & E-health (H.O.P.E), a chronic disease management program that helps high-risk patients manage symptoms. The H.O.P.E program uses daily monitoring and feedback from telehealth nurses to reduce both emergency room visits and hospitalizations.

Provider Relations contracted with two new urgent care centers in late 2013, and the service coordinators have been educating members about this avenue for urgent care type services.

CMS-416 EPSDT Measures Initiatives

For one health plan, service coordinators currently maintain a resource file that includes updated listings of providers and specialists in various geographical areas who have open panels and are accepting new patients. The resource file is continually updated, expanded, and shared through e-mail blasts among service coordinators. The plan's EPSDT coordinator follows up on referrals documented on the EPSDT forms (8015 and 8016 forms) to ensure that pediatric members follow through on referrals made. In addition, the plan does not require a PCP to obtain authorization for a referral to an in-network specialist. This ensures that there are no delays with specialty referrals.

To facilitate better access, another plan has implemented its PCMH model which includes reviewing scheduling patterns from providers and recommending an attempt to shift to an open access scheduling model. The open access scheduling model allows for blocks of time that are free for same day appointments and walk-ins, helping minimize wait times for scheduled members. The health plan recommended that providers conduct pre-visit planning to ensure that members have adequate time for their needs. For example, during a pre-visit planning session, a member identified as requiring an EPSDT visit would be scheduled for a 30–45 minute time slot. This allows for a thorough visit with time to administer immunizations and perform diagnostic tests.

Through one plan's outreach program, an EPSDT coordinator outreached to pediatric members to educate and assist with scheduling appointments for well-visits and immunizations updates.

CAHPS (QUEST & QExA) Initiatives

As part of its strategy to improve CAHPS, the health plans supports and promotes the following activities that build the provider-patient relationship and the importance of members' engagement in their care, which can lead to better satisfaction and access to care.

Rating Of Health Plan And Customer Service

Ways The Health Plans Assessed And Evaluated The Membership Experience With The Health Plan:

- Quarterly focus groups
- Member grievances related to appointment availability or access to care are monitored real time for investigatory purposes and trended quarterly to identify providers receiving multiple complaints regarding access.
- Plan's Community Advocacy staff held health presentations monthly throughout the State where members may provide feedback about member experience (which is then brought to the appropriate department for follow up).
- QUEST Timely Access and telephonic timely access Surveys monitored access to care to measure appointment availability.

Actions Taken By Health Plans To Ensure Personnel Are Equipped To Address And Take Care of Member Concerns

Customer Service:

- New hire onboarding and on-going training provided
- Training for customer service staff includes average speed of answer, service levels, average handling time, customer satisfaction, first call resolution, and quality to measure the success of service and the ability to assist members.
- Focuses on various metrics which are tracked monthly and evaluated. When metrics are not met, analysis is conducted and corrected accordingly.
- CAHPS Associate Monthly Award program recognized actions which encompassed the core ways of increasing member satisfaction.
- Quality Improvement Team- quality-focused in-service training sessions for all departments.
- Member surveys done to gather member perception regarding wait time standards and experiences in getting in to see a provider.

Follow-Up Calls:

Health Services team, disease management nurses, the Complex Case Management program and service coordinators call members when they close the program or are discharged to determine if members were satisfied with the services. The health plan reported 85 to 95 percent satisfaction rates for these programs. Examples of areas for improvement noted

Workgroups Created To Improve Health Care Processes:

- Utilization Medical Advisory Committee (UMAC) - Engages in the plan's processes with physician attendance and reviewing and monitoring of processes and data, making recommendations as needed.
- Quality Improvement Intervention Workgroup (QIIW) - Takes a collaborative approach to improving quality health care.
- Members Matter Advisory Committee (MMAC) - To have and strengthen a formal means of communication with members.
- Member Advisory Group (MAG) - Advises on issues concerning the overall member experience.

Getting Needed Care & Getting Care Quickly Initiatives

Efforts By The Health Plans To Expand Access To A Provider:

- "Find a Provider"- An online tool.
- Customer Services
- Self-Refer for Specialists- Allows members to self-refer for many specialties.
- The access and availability grant program provided funding, providing $300,000 in grants, to neighbor island providers to recruit new primary care and behavioral health practitioners to their communities.
- Enhancement of the PCMH model which improved patient access, including assigning patients to a designated primary care team, developing open access scheduling, and redefining care team member roles to free up appointment access and accommodate same day services. Six of these health centers have now received PCMH recognition from NCQA.
- As part of the PCMH program, an incentive to include a stipend to providers who were open panel and willing to accept new 'members.
- Services that are available twenty-four hours day, seven days a week: 24/7 Nurse Call Line, 24/7 Access and Live Nurse Chat are
- In 2014, the Teladoc service, a 24/7 access to a doctor via phone and online video consultations relayed through NurseLine, was upgraded with the NowClinic, an online care solution platform to connect members and providers.
- In-home visits by health care practitioners to assess health conditions and evaluate members' current health care needs and make recommendations.

Methods Utilized By The Health Plans To Assist With Preventive Visits, Appointment Scheduling And Screenings Due:

- Cozeva – An online tool.
- Centralized Telephonic Outreach Program - Also includes care gap and assists with transportation and interpretation services when needed.
- "Max-packing"- Appointments are consolidated around members' transportation availability and is conducive to meeting with the member face to face while they are at one location for multiple appointments.
- Member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.
- Periodicity letters sent to members are specific to gender, age, and chronic conditions. Also explains the importance of these visits and what to expect. This encourages communication regarding their health care and/or treatment options.
- Patient Reminder Cards
- "Quick reference card"- Includes all important phone numbers
- Informative handbooks
- In 2013, the Hawaii 5-2-1-0 information (related to Hawaii's campaign to promote healthy lifestyles and prevent childhood obesity) and member handbook was translated into other languages such as Ilocano, Korean, Chinese, and Vietnamese in an effort to improve patient health literacy.

Methods Utilized By The Health Plan To Address And To Assist With Care Gaps:

- Personal Health Record (A piloted project) - Remains in member's home and is updated at each face-to-face visit.
- CARE Connects links to members through the customer service phone lines.
- "Family-Centered Care Self-Assessment Tool"- Increases outpatient health care providers' and families' awareness about the implementation of family-centered care
- Information about the referral process and quick reference guides are available on the plans' website, distributed in-person or by mail.
- No-show appointment follow-up process revitalized for one health plan
- Care Gap Reports- Given to providers and available via the provider portal. It has a built-in reminder system for services due and overdue.
- Created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.
- Warm transfers of all medication-related calls from Customer Service to pharmacy staff.
- Pharmacy and Therapeutics (P&T) Advisory Committee regularly reviews the formulary to ensure medically appropriate and cost-effective drugs are accessible. In addition, certain system edits are in place to check to ensure that members are using their medications safely and that drugs are monitored for effectiveness.
- As a result of close collaboration between the health plan and its clinical partners, one health plan was able to identify areas of opportunity that could be streamlined to remove unnecessary burden to the provider and to improve timely access to care and service for the member. An example is the change to the prior approval process to cover diabetic supplies for pregnant women with impaired glucose tolerance.

- Close collaboration between the health plan and its clinical partners, the health plan was able to identify areas of opportunity that could be streamlined to remove unnecessary burden to the provider and to improve timely access to care and service for the member. An example is the change to the prior approval process to cover diabetic supplies for pregnant women with impaired glucose tolerance

Rating Of Personal Doctor

Actions Taken By Health Plans To Ensure Quality Provider Performance:

- Providers are educated about member rights to choose a specialist as a PCP to encourage the right match of providers.
- Surveys are conducted to determine provider compliance with appointment availability standards. Providers identified as noncompliant with the standards are provided direct education and feedback.
- Practice Matters provider newsletter and the Provider Administrative Guide distributed.
- Educational and informative articles such as "Communicating Effectively for Coordination of Care" are included.
- Health presentations given monthly throughout the State which integrated the necessity of feeling comfortable talking with one's provider.
- Access to online tools that make communication with their providers easy and convenient
- System enhancements are conducted frequently to remain current with the latest technologies. Those systems assist in completing, tracking, monitoring, and trending reports.
- Providers are encouraged to render the best care to its membership and to promote open communication including nonverbal communication such as ensuring eye contact and active listening.
- Provider relations representatives educate providers on accessibility of timely appointments required by Med-QUEST and NCQA during provider orientation and ongoing education sessions. Providers not meeting requirements may be expected to produce a corrective action plan.
- Providers are trained on members' rights and their responsibilities to adequately care for members. Provider wait times are also monitored and tracked through grievances. If a complaint is received, staff reaches out to the provider, investigates, educates, and provides feedback on findings.
- In 2013, primary care providers were given monthly "report cards" showing their performance on selected HEDIS performance measures. Feedback from providers on these reports has been positive.
- Cultural competency improvement initiative for providers.

Physicians' Assessment Initiatives

Efforts Made By The Health Plans To Increase Provider Satisfaction:

- Improved the knowledge base of their employees through various training modalities and initiated improvements to the prior authorization (PA) process.

- Office Advisory Group- Consists of the providers' office staff who are also being engaged in the plan's processes.

- Changes to PA requirements to reduce the burden on providers. These changes are being implemented in 2014.
- Improved system capability to allow online submission and approval of PAs is being implemented.
- Conducted provider training sessions in person on all islands to improve provider understanding of requirements and to address provider issues and concerns.
- PCPs may use an online secure portal to request PA for referrals to out-of-network specialists/providers. These requests are reviewed and responded to within the time frame allowed by the MQD. Providers are encouraged to call in "URGENT" requests to ensure timely review and response.
- Network providers are notified regularly in writing and at least 30 days in advance of any drugs deleted and/or added to the formulary.
- Direct servicing offered without going through a local vendor as done in the past. The newly formed provider advocate team has been trained to assist providers with educational needs, claims resolution, and contracting needs. This new model is designed to ensure that providers have access to the resources available to them and to ensure that claims are paid timely and accurately. Direct provider servicing aims to enhance the provider's experience.
- Aerial, a health care management platform implemented in early 2013, helps monitor and track authorization requests from date of receipt to date of outcome decision. An online tool to accept/process authorizations is also available.
- Created and implemented a tool—Clinical Guidelines for Authorization—in collaboration with some providers selected to participate in the Office Advisory Group.
- Training Sessions provided based on provider-and member-specific issues and trends, or high volume inquiries. Staff member are also given one-on-one coaching to ensure servicing/knowledge consistency and competency.
- Areas of opportunity identified that could be streamlined to remove unnecessary burden to the provider and to improve timely access to care and service for the member.
- Providers reminded of the ability to submit and check status of PAs online.

Plans' All-Cause Readmission Initiatives

- Implemented a new 30-day hospital readmission program called AHOP (After Hospital Outreach Program) targeting members with congestive heart failure to help prevent hospital readmissions. Interventions include health education, follow-up appointments, transportation, and collaboration with PCP.
- Submitted a Preventive Care Checklist of HEDIS-related tests and procedures to the State and is awaiting approval for its use for members.
- In February 2014, one health plan pulled (by diagnosis) the top 20 members over utilizing the ER. These members were discussed at the HURRT meetings. This includes an interdisciplinary team of clinical staff (medical, social work, and behavioral health), managers, and medical directors (medical and behavioral health) to review the "super utilizers" (i.e., top 1 percent of utilizers, complex medical/behavioral health cases). Case reviews are presented on the members most frequently readmitted to the hospital and/or with the highest ER usage and provide a comprehensive recommendation to the specific service coordinator/case manager to incorporate in the member's care plan. This health plan reports that it has seen a decrease in readmission rates for those members who had interventions through this interdisciplinary team. As stated previously, the utilization of the HURRT has decreased ER utilization and readmission rates for those members presented to the HURRT.

- A new performance improvement projects (PIPs) in CY 2013 was *Plan All Cause Readmissions*.
- In 2014, one health plan partnered with H.O.P.E. to reduce both emergency room visits and hospitalizations.
- In late 2013, one plan introduced its member/family-centric Clinical Effectiveness Initiative (CEI) Model. The CEI Model is based upon a fundamental whole-person approach across all points of service and the continuum of care.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
    - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to "get into a waiver."
    - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
    - Choices offered include:
        - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
        - Residential settings such as community care foster family homes or assisted living facilities
        - Institutional setting
    - Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
    - DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation
- Standardized assessment tools for HCBS
    - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
    - The use of these assessment tools have helped to streamline receipt of services

Hawaii Medicaid Enrollment Initiatives

- MQD is focused on assuring processing of applications for Medicaid within 45-days or else providing presumptive eligibility.

- MQD has enacted eligibility for beneficiaries' five-days prior to submittal of application to assure that medical services received will be covered.

- MQD has amended its 1115 demonstration waiver to provide eligibility up to 133% (with a 5% disregard) of Federal Poverty Level for implementation of ACA.

Other Quality Projects

MQD continues to work on strategies and measures related to home and community based services, which will affect mostly our QExA health plans, the Developmental Disability and Intellectual Disability (DD/ID) program, and the Going Home Plus (GHP) program. MQD started implementing CMS' Quality Framework for Home and Community Based Services (HCBS) in SFY2012. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority.

MQD developed behavioral health monitoring tools to measure the transition and on-going implementation of providing behavioral health services for Hawaii's Medicaid SMI population. Some of the areas measured include:

- Services provided
- Health plans meeting case management acuity (i.e., assuring that case managers are meeting with their clients in accordance with timeframes established during a psychosocial assessment)
- Acute psychiatric hospitalizations
- Discharge planning and follow-up with seven days after an acute psychiatric hospitalization
- Management of sentinel events

Measures for inpatient care and long-term care will need to be developed in the future in partnership with our stakeholders. Measures for the QUEST and QExA populations will vary.

Our quality approach aspires to 1) have collaborative partnerships among the MQD, health plans, and state departments; 2) advance the patient-centered medical home; 3) increase transparency- including making information (such as quality measures) readily available to the public; 4) being data driven; and 5) use quality-based purchasing- including exploring a framework and process for financial and non-financial incentives.

Quality Activities during the demonstration year

The State of Hawaii, Med-QUEST Division has a contract with Health Services Advisory Group (HSAG) to perform its EQRO activities. In 2014, MQD moved into the second of its three year cycle for mandatory external quality review that is described in Code of Federal Regulations (CFR) at 42 CFR 438.358. For this review, the HSAG performed a desk review of documents and an on-site review of the re-evaluation of health plan compliance that included reviewing additional documents and conducting interviews with key staff members from each health plan. HSAG evaluated the degree to which each health plan complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to the access and measurement and improvement standards in 42 CFR 438.214-230, Subpart D. The five standards included requirements that addressed the following areas:

- Subcontractors and Delegation
- Credentialing
- Quality Assessment and Performance Improvement
- Health Information Systems
- Practice Guidelines

Each health plans was provided a report that described their areas of success as well as areas for improvement. Corrective Action Plans (CAP) was required for areas requiring improvement. Across all five plans subcontractors and delegation had the highest number of CAPs.

HSAG performed Performance/HEDIS validation reports as well as PIP reports. In regards to the PIPs, in 2014:

- All health plans performed well in the Design stage. This indicates plans demonstrated the ability to document required information for that stage of their PIPs. The health plans designed scientifically sound studies supported by use of key research principles. The design of the PIPs promoted progression to the next stage of the PIP process.
- All health plans performed well in the Implementation stage. These findings suggest health plans accurately documented a thorough process for analyzing data, identifying barriers, and developing interventions.
- All health plans' PIPs received an overall *Met* validation status.

A variety of suggested activities was provided to the health plans that included conducting causal barrier analysis and improving PIP documentation. Other EQRO activities include the completion of the CAHPS Child survey for the CHIP population and CAHPS Adult survey for each health plan with the finalization of reports.

In addition, the EQRO completed the Annual Technical Report, which includes follow-up and updates from the previous year's Technical report submitted from the health plans. The Annual Technical Report is posted on the MQD website. We also continue to do inter-rater reliability reviews with our PRO level of care determinations.

We are continuing to actively working on strategies and measures related to home and community based services. These include establishing guidelines and reporting requirements as well as oversight of grievance and appeals processes, nursing assessments, among others. We have met with the health plans to do an overview, and we will follow-up with regular meetings with the health plans specifically for the implementation of HCBS monitoring.

Most importantly, we are establishing and implementing an internal quality flow processes that will guide all quality activities from reporting to analysis to corrective action to system changes. We are establishing Quality Committees and Leadership Teams according to the Quality Strategy.

Improvement of Health Plan Report Forms and Monitoring Tools

In demonstration year 20, MQD continues to align the report forms and monitoring tools for these programs wherever possible. MQD is developing tools for health plan reporting and review tools for MQD staff to use to standardize report analysis. This process is ongoing and will continue into demonstration year 21. Prior to any health plan report tool being issued, MQD receives input from the QUEST and QExA health plans. MQD has templates implemented for all reports submitted.

Cost of Care

Financial Performance of the Demonstration

The Demonstration expended approximately $670 million to provide services to Medicaid clients in Hawaii (both State and Federal funds). See Attachment C for summary of financial expenditures for demonstration year 20 (July 1 to December 31, 2013).

Financial/Budget Neutrality Development/Issues

The MQD submitted budget neutrality for each quarter in demonstration year 20.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	July to September 2013 (1st qtr totals)	October to December 2013 (2nd qtr totals)	January to March 2014 (3rd qtr totals)	April to June 2014 (4th qtr totals)
Children (EG1)	431,322	332,052	346,435	343,968
Adults (EG2)	308,635	153,459	168,664	166,311
Aged (EG3)	63,574	64,888	67,922	68,387
Blind/Disabled (EG4)	73,164	73,594	74,414	74,844
EG 5-VIII-Like Adults	N/A	171,985	6,985	378
EG 6-VIII Group Combined	N/A		205,646	235,272

B. For Informational Purposes Only

With Waiver Eligibility Group	July to September 2013 (1st qtr totals)
State Plan Children	330,313
State Plan Adults	114,550
Optional MQD Plan Children	
Optional MQD Plan Children MCHP	90,345
CHIPRA	10,490
Foster Care Children	174
Medically Needy Adults	
Demonstration Eligible Adults (QUEST & QUEST-Net Adults)	99,766
Demonstration Eligible Adults (QUEST-ACE)	94,319
Aged with Medicare	58,780
Aged without Medicare	4,784
Blind/Disabled with Medicare	30,715
Blind/Disabled without Medicare	42,370
Breast and Cervical	79

With Waiver Eligibility Group	October to December 2013 (2nd qtr totals)	January to March 2014 (3rd qtr totals)	April to June 2014 (4th qtr totals)
State Plan Children	331,573	345,846	343,241
State Plan Adults	142,023	168,105	166,216
Aged	64,888	67,922	68,387
Blind or Disabled	73,594	74,414	74,844
Expansion State Adults		72,106	98,896
Newly Eligible Adults		113,540	136,376
Optional State Plan Children			
Foster Care Children, 19-20 years old	479	589	727
Medically Needy Adults			
Demonstration Eligible Adults	11,436	559	95
Demonstration Eligible Children			
VIII-Like Group	171,985	6,985	378

Audits and Lawsuits

Audits

The MQD undergoes an audit annually that includes managed care programs. The audit was held in December 2013. No deficiencies in managed care areas were found in this audit.

Lawsuits

One member filed a lawsuit in circuit court related to health plan's processing of denial of services. The DHS has prevailed in this lawsuit in 2014. The lawsuit was appealed to the Intermediate Court of Appeals for review; DHS prevailed in the appeal. The member is able to either request a reconsideration or file with the Hawaii supreme court.

Demonstration Programmatic Information specific to QUEST Expanded Demonstration
QUEST, QUEST Expanded Access (QExA), and Fee-For-Service (FFS) Concerns

The MQD has two areas that address consumer issues. The MQD Customer Service Branch and the Health Care Services Branch, Quality and Member Relations Improvement Section (HCSB/QMRI). Both of these areas addressed consumer issues for the QUEST, QExA, and Fee-For-Service (FFS) programs. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (either QUEST or QExA), they transfer those telephone calls to the HCSB. The clerical staff person(s) takes the basic contact information and assigns the call to one of the social workers. MQD tracks the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., into a QExA health plan), then the CSB will work with the client to resolve their issue. Below are charts for QUEST, QExA, and the FFS program for DY 20.

QUEST Consumer Issues
During the demonstration year 20, the HCSB/QMRI, as well as other MQD staff, processed approximately 15 member and provider telephone calls and e-mails (see table to the right) for the QUEST program.

	Member			Provider		
	QUEST	QExA	FFS	QUEST	QExA	FFS
July to September 2013	5	21	3	0	15	12
October to December 2013	0	20	2	0	9	11
January to March 2014	2	21	2	1	9	14
April to June 2014	5	32	6	2	10	16
Total	12	94	13	3	43	53

Through implementation of the QExA program, HCSB/MPRS has formalized processes to address consumer issues. The processes have been formally communicated to the public through the QExA program, but not yet for the QUEST program. Despite communication during SFY2013, HCSB/QMRI has not seen a larger number of consumers contact us regarding the QUEST program.

QExA Consumer Issues
During the demonstration year 20, the HCSB/QMRI staff, as well as other MQD staff, processed approximately 94 member and provider telephone calls and e-mails (see table above). These numbers are not distinct members or providers, but are distinct issues. The number of calls from members is approximately 60% than from last year (SFY13) and approximately 32% of the start of QExA when the HCSB received approximately 73 member calls in the first quarter of 2009.

The number of provider calls is approximately 13% of the number of calls that the HCSB staff received in the first quarter of 2009- January to March 2009 (82 provider calls).

FFS Consumer Issues
During the demonstration year 20, the HCSB/MPRS, as well as other MQD staff, processed approximately 66 member and provider telephone calls and e-mails (see table above). These numbers are not distinct members or provider, but are distinct issues. As noted, this number continues to increase each quarter. Through implementation of the QExA program, HCSB has formalized processes to address consumer issues. The processes have been formally communicated to the public through the QExA program, but not yet for the FFS program. In addition, though the FFS program is small, HCSB continues to receive calls from both FFS members and providers.

The MQD and the QExA health plans continue to have two regularly scheduled meetings. One of the

meetings is a monthly meeting with the Case Management Agencies. The meetings with these agencies are focused around continually improving and modifying processes within the health plans related to HCBS. In addition, a QExA transition group formed on the island of Maui. This group meets bi-monthly to address Maui specific issues regarding QExA. The members of this group are mostly other State agencies as well as a few provider groups (i.e., one of the FQHCs on Maui) and a few QExA consumers. The primary issue being addressed at this time is growing the health plans provider networks on Maui.

Most of the communication with providers occurs via telephone and e-mail at this time. The MQD will arrange any meetings with QUEST or QExA health plans and provider groups that are requested.

The MQD estimates that provider call volume has decreased due to frequent meetings with the providers throughout the program as well as the health plans addressing provider issues when the health plan is contacted first.

Appeals

During the demonstration year 20, the HCSB processed 30 appeals (see table to below). All of these appeals were appealing the health plans decision to reduce or deny services. In these appeals, the hearing officer felt that the actions taken by the health plan were not appropriate (i.e., the appeal was overturned) in 3 of the 11 appeals (27%). The hearing officer felt that the actions taken by the health plan were appropriate (i.e., the appeal was upheld) in 8 of the 11 appeals (73%). In addition, 19 of the 30 appeals through administrative resolution were withdrawn or dismissed because MQD did not agree with the health plan's denial or reduction or the member had not gone through the health plan appeal process first. In these situations, through MQD's intervention, the beneficiaries received the services that they had submitted the appeal for initially. Administrative resolution was approximately 63.3% of the appeals.

Types of Appeals	#
Medical	7
LTSS	13
Other: Wheelchair, Medications, Transportation	4

Category	#
Submitted	30
DHS resolved with health plan in member's favor prior to going to hearing	19
Hearings	
Resolution in DHS favor	8
Resolution in Member's favor	3

Enrollment of individuals

	#
Individuals who chose a health plan when they became eligible	194
Individuals who changed their health plan after being auto-assigned	12,557
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	521
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	42

The DHS enrolled approximately 34,400 members from October 1, 2013 to June 30, 2014. Of this group, 194 chose their health plan when they became eligible, 12,557 changed their health plan after being auto-assigned.

In addition, DHS had 521 plan-to-plan changes from October 1, 2013 to June 30, 2014. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 42 individuals in the QUEST Expanded

Access (QExA) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

Behavioral Health Programs Administered by the DOH and DHS

The DHS assumed approximately 3,700 individuals from the Adult Mental Health Division (AMHD) under the Department of Health (DOH) on September 1, 2013. In addition, MQD transitioned approximately 1,500 individuals from the QUEST program to the behavioral health program called Community Care Services (CCS) program. Individuals in CCS have a Serious Mental Illness (SMI) diagnosis with functional impairment. The Medicaid beneficiaries who continue to receive services from AMHD are legally encumbered. These individuals are under court order to be cared for by AMHD. The information provided in the table above identifies that the AMHD continues to provide services to 261 Medicaid beneficiaries. The CCS program has a little over 6,000 individuals.

Program	6/30/14
Adult Mental Health Division (AMHD/DOH)	261
Child and Adolescent Mental Health Division (CAMHD/DOH)	3,300
Community Care Services (CCS/DHS)	6,025

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). CAMHD is providing services to approximately 3,300 children as of June 30, 2014.

Reporting

The MQD receives reports consistent with the reporting requirement in the QUEST and QExA RFPs. MQD staff review quarterly and annual reports for compliance with the QUEST and QExA programs.

The MQD receives a monthly Dashboard report for both QUEST and QExA programs. The MQD uses the Dashboard to share information on the programs with the public. The Dashboard contains information on member and provider demographics, call center statistics, claims processing, complaints from both members and providers, and utilization data. The July 1 to December 31, 2013 compilation of the Dashboards are attached as Attachment D and the January 1 to June 30, 2014 versions of the Dashboards are attached as Attachment E.

Annual Plan Change

QUEST Annual Plan Change (APC) was in August 2013. 8,260 individuals chose a new health plan that went into effect on October 1, 2013. Approximately 3.3% of the QUEST population chose a new health plan in 2013.

Annual Plan Change for QUEST- Aug 2013	
	# of health plan changes (loss to plan)
AlohaCare	3,518
HMSA	2,496
Kaiser	291
‘Ohana	1,012
United	942
Total	8,260

QExA Annual Plan Change (APC) was in November 2013. 584 members changed health plans during APC. 326 individuals left ‘Ohana and 258 left United.

Annual Plan Change for QExA- Nov 2013	
	# of health plan changes (loss to plan)
‘Ohana	326
United	258
Total	584

Home and Community Based Services (HCBS) Waiting List
The QExA health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity
MQD monitors the number of clients receiving HCBS when long-term care services were required. The number of clients requiring long-term services and supports (LTSS) continues to rise. In the second quarter of 2014, the number of individuals receiving LTSS has increased by approximately 46.4% since the start of the program. HCBS has absorbed all of this increase instead of nursing facility services. Nursing facility services have decreased by approximately 10.3% since program inception.

	2/1/09	2nd Qtr 2014, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 2nd Qtr 2014
HCBS	2,110	4,699	123%↑	42.6%	64.9%↑
NF	2,840	2,546	10.3%↓	57.4%	35.1%↓
Total	4,950	7,245	46.4%↑		

The number of clients receiving HCBS has increased by approximately 123%. At the start of the program clients receiving HCBS was 42.6% of all clients receiving long-term care services. This number has increased to almost 65% (64.9%) since the start of the program.

QUEST Integration transition
The DHS was procuring the QUEST Integration program during the first quarter of FFY14. The Request for Proposals was issued on August 5, 2013. Proposals were submitted on November 1, 2013. The DHS was evaluating proposals from November 2, 2013 through January 4, 2014.

The DHS started QUEST Integration transition or readiness review for QUEST Integration health plans on February 1, 2014. Readiness review during the third quarter of FFY14 consisted of submission of documents to MQD for review and MQD’s review of those documents. MQD developed a process for tracking, review and return of submissions. In addition, MQD developed review tools for assuring that all deliverables meet contract requirements.

During this quarter, MQD performed three trainings for health plans. Trainings were:

- Putting QI into EPSDT
- Why It‘s Not Good Enough to Be Patient & Family Centered… Honoring Diversity

- Leading the Way to Make Sure Your Consumer Directed Program is on the Right Path

During this quarter, MQD developed of standardized health and functional assessment and service plan tools. These tools were issued to health plans the end of the third quarter of FFY 14. In addition, MQD developed templates for meeting Federal regulations for the Grievance system.

Status of the Demonstration Evaluation

MQD submitted its final demonstration evaluation to CMS on January 24, 2014 during Demonstration Year 20.

MQD Contact(s)

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Tables

Table 1A - Enrollment Counts from June 2013 to September 2013

	June 2013	September 2013	Percent Change
By Program			
QUEST			
1925- Transitional Medicaid	6,558	6,390	(2.6 %)
Adult/Children AFDC Family members covered by Section 1931	87,993	87,661	(0.4 %)
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	5,020	4,934	(1.7 %)
General Assistance	5,497	5,335	(2.9 %)
QUEST-Net	11,833	12,271	3.7 %
QUEST	49,758	48,230	(3.1 %)
QUEST-ACE	26,525	28,746	8.4 %
S-CHIP	28,890	29,315	1.5 %
TANF	15,198	15,497	2.0 %
QUEST Total	**237,272**	**238,379**	**0.5 %**
QUEST Expanded Access (QExA)			
Aged, Blind, Disabled (ABD)	43,577	43,718	0.3 %
QExA Spenddown	2,415	2,435	0.8 %
Other (QMB, SLMB, QDWI)	4,091	4,206	2.8 %
QExA and other ABD Total	**50,083**	**50,359**	**0.6 %**
BHH (Basic Health Hawaii)/ QUEST State Funded	5,055	4,949	(2.1 %)
QUEST/QExA/Other Total	**292,423**	**293,687**	**0.4 %**
Health Plan			
AlohaCare	69,690	66,636	(4.4 %)
HMSA	130,918	133,011	1.6 %
Kaiser	23,167	24,784	7.0 %
‘Ohana QUEST	9,581	9,950	3.9 %
United QUEST	8,892	8,863	(0.3 %)
QUEST FFS Window	92	84	(8.7 %)
QUEST Total	**242,340**	**243,328**	**0.4 %**
‘Ohana QExA	24,572	24,522	(0.2 %)
United QExA	21,364	21,576	1.0 %
QExA Total	**45,946**	**46,098**	**0.3 %**
Island			
Oahu	179,227	179,901	0.4 %
Kauai	16,072	16,287	1.3 %
Hawaii	62,145	62,854	1.1 %
Maui	30,951	30,586	(1.2 %)
Molokai	3,305	3,338	1.0 %
Lanai	723	721	(0.3 %)
Total	**292,423**	**293,687**	**0.4 %**

Table 1B - Enrollment Counts from October 2013 to June 2014

	October 2013	June 2014	Percent Change
By Program			
QUEST			
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	4,926	5,804	17.8 %
Adults	55,962	81,803	46.2 %
Adult caretakers	41,388	44,053	6.4 %
Children	103,463	108,417	4.8 %
S-CHIP	29,597	28,722	(3.0 %)
QUEST (Medical extension)	2,437	0	(100 %)
QUEST Total	**237,773**	**262,995**	**10.6 %**
QUEST Expanded Access (QExA)			
Aged, Blind, Disabled (ABD)	43,020	48,892	13.6 %
QExA Spenddown	3,194	0	(100%)
Other (QMB, SLMB, QDWI)	4,184	1,185	(71.7 %)
QExA and other ABD Total	**50,398**	**50,077**	**(0.6 %)**
BHH (Basic Health Hawaii)/ QUEST State Funded	5815	6,634	14.1 %
QUEST/QExA/Other Total	**293,986**	**325,510**	**10.7 %**
Health Plan			
AlohaCare	66,254	69,113	4.3 %
HMSA	133,035	149,344	12.3 %
Kaiser	24,708	25,743	4.2 %
‘Ohana QUEST	10,236	16,196	58.2 %
United QUEST	9,090	14,782	62.6 %
QUEST FFS Window	265	0	(100 %)
QUEST Total	**243,588**	**275,178**	**13.0 %**
‘Ohana QExA	24,632	26,665	8.3 %
United QExA	21,749	23,667	8.8 %
QExA Total	**46,381**	**50,332**	**8.5 %**
Island			
Oahu	180,087	199,062	10.5 %
Kauai	16,384	18,255	11.4 %
Hawaii	62,413	69,081	10.7 %
Maui	30,485	34,896	14.5 %
Molokai	3,346	3,462	3.5 %
Lanai	719	754	4.9 %
Total	**293,986**	**325,510**	**10.7 %**

Table 1C - Enrollment Counts – Medicare Sharing Programs

Medicare Sharing Program	June 2013	June 2014	Percent Change
H37 - QMB ONLY	184	275	49.5 %
H37 - QMB ONLY CFA	2	0	(100 %)
H39 - SLMB	3,869	3,162	(18.3 %)
H39 - SLMB CFA	6	3	(50 %)
H40 - QDWI	0	2	100 %
G01 - QUALIFIED INDIVIDUAL	0	1,110	100 %
Total	4,061	4,552	12.1 %

Table 2- Benefits for QUEST and QExA

	QUEST	QExA
Primary and Acute Care Services		
Cognitive rehabilitation services		X
Cornea transplants and bone graft services	X	X
Durable medical equipment and medical supplies	X	X
Emergency and Post Stabilization services	X	X
Family planning services	X	X
Home health services	X	X
Hospice services	X	X
Inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care	X	X
Maternity services	X	X
Medical services related to dental needs	X	X
Other practitioner services;	X	X
Outpatient hospital services	X	X
Personal assistance services - Level I		X
Physician services	X	X
Prescription drugs	X	X
Preventive services	X	X
Radiology/laboratory/other diagnostic services	X	X
Rehabilitation services	X	X
Smoking Cessation	X	X
Sterilizations and hysterectomies	X	X
Transportation services	X	X
Urgent care services	X	X
Vision and hearing services	X	X
Inpatient psychiatric hospitalizations	X	X
Ambulatory mental health services and crisis management	X	X
Medications and medication management	X	X
Psychiatric or psychological evaluation and treatment	X	X
Medically necessary alcohol and chemical dependency services	X	X
Methadone management services	X	X
Intensive Care Coordination/Case Management	X	
Partial hospitalization or intensive outpatient hospitalization	X	
Psychosocial Rehabilitation	X	
Therapeutic Living Supports	X	

	QUEST	QExA
Long-Term Care Services		
Home and Community Based Services:		
Adult day care		X
Adult day health		X
Assisted living services		X
Attendant care		X
Community Care Management Agency (CCMA) services		X
Community Care Foster Family Home (CCFFH) services		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals		X
Home maintenance		X
Medically fragile day care		X
Moving assistance		X
Non-medical transportation;		X
Personal assistance services – Level I and Level II		X
Personal Emergency Response Systems (PERS)		X
Private duty nursing		X
Residential care		X
Respite care		X
Specialized medical equipment and supplies		X
Institutional Services:		
Nursing Facility services	X	X

Table 3- Carve-Out programs

The programs listed below are provided outside of either the QUEST or QExA programs. If a program is not checked, it is either provided within the program or not offered at all due to eligibility criteria in QUEST and QExA.

	QUEST	QExA
Adult Mental Health Division	Within QUEST	X
Child and Adolescent Mental Health Division	X	X
Community Care Services (Behavioral Health program administered by DHS)	Within QUEST	X
Dental Services	X	X
Developmental Disabilities/Intellectual Disabilities (DD/ID) 1915(c) waiver		X
School Based Services	X	X
State of Hawaii Organ Transplant Program (SHOTT)	X	X
Vaccines for Children	X	X
Zero to Three (Early Intervention)	X	X

QUEST HEDIS 2014 Measures

			HYBRID or ADMIN
I	**Effectiveness of Care**		
	Adult BMI Assessment	ABA	H
*	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Human Papillomavirus Vaccine for Female Adolescents (New)	HPV	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for Nutrition	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
*	Chlamydia Screening in Women	CHL	A
	Appropriate Testing for Children With Pharyngitis	CWP	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Medication Management for People with Asthma (New)	MMA	H
	Cholesterol Management for Patients with Cardiovascular Conditions	CMC	H
*	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
*	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	LDL-C Screening Performed		H
*	LDL-C Screening Level < 100 mg/dL		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 80		H
*	Systolic and Diastolic BP Levels < 140 / 90		H
	Use of Imaging Studies for Low Back Pain	LBP	A
	Antidepressant Medication Management	AMM	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventitive/Ambulatory Health Services	AAP	A
	Childrens' & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Prenatal		
	Postpartum		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

Will be validated by EQRO.
* P4P 2014

QExA HEDIS 2014 Measures

			HYBRID or ADMIN
I	**Effectiveness of Care**		
	Adult BMI Assessment	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for Nutrition	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Appropriate Testing for Children With Pharyngitis	CWP	A
	Care for Older Adults (New)	COA	H
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Cholesterol Management for Patients with Cardiovascular Conditions	CMC	H
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	LDL-C Screening Performed		H
	LDL-C Screening Level < 100 mg/dL		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 80		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Use of Imaging Studies for Low Back Pain	LBP	A
	Antidepressant Medication Management	AMM	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
	Flu Vaccinations for Adult Ages 18-64 (New)	FVA	CAHPS
	Medical Assistance With Smoking and Tobacco Use Cessation (New)	MSC	CAHPS
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventitive/Ambulatory Health Services	AAP	A
	Childrens' & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Prenatal		
	Postpartum		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

Will be validated by EQRO.

Hawaii Adult Medicaid CAHPS 2014 Results – QUEST

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Adult Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to QUEST members.[1,2] Survey participants included adult Medicaid members who were 18 years of age or older and enrolled in a QUEST health plan from July 1, 2013 through December 31, 2013. The following health plan satisfaction ratings are based on the responses of 2,311 members who completed the survey.[3] It is important to note that in calendar year 2014 both 'Ohana Health Plan's ('Ohana's) and UnitedHealthcare Community Plan's (UHC CP's) QUEST adult Medicaid populations were surveyed for the first time. The 2014 CAHPS results presented in this report represent an initial **baseline** assessment of adult members' satisfaction with their 'Ohana or UHC CP QUEST health plan; therefore, caution should be exercised when interpreting these results.

Table 1 shows the overall member satisfaction ratings on each comparable CAHPS measure for the QUEST health plans.

Table 1
Overall Member Satisfaction Ratings for QUEST Health Plans

	How Members Rated				
	Health Plan	**Personal Doctor**	**Customer Service**	**Getting Needed Care**	**Getting Care Quickly**
QUEST Health Plan					
AlohaCare QUEST	★★	★★★★	★	★	★
Hawaii Medical Service Association QUEST	★★★	★★	★+	★	★
Kaiser Permanente Hawaii QUEST	★★★★★	★★★★★	★★★+	★★	★★★
'Ohana Health Plan QUEST	★	★★★	★	★	★
UnitedHealthcare Community Plan QUEST	★	★★	★+	★	★

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 2,311 members who completed the CAHPS 5.0H Adult Medicaid Health Plan Survey between February and May 2014. QUEST health plans were compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditation.

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] AlohaCare's, Hawaii Medical Service Association's, Kaiser Permanente Hawaii's, 'Ohana Health Plan's, and UnitedHealthcare Community Plan's QUEST ratings are based on the responses of 447, 552, 562, 382, and 368 members who completed a survey, respectively.

Table 2 shows the three-point mean scores on each comparable CAHPS measure for the QUEST health plans.

Table 2
Average Ratings and Composite Scores for QUEST Health Plans

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QUEST Health Plan					
AlohaCare QUEST	2.37	2.54	2.41	2.20	2.26
Hawaii Medical Service Association QUEST	2.43	2.49	2.35+	2.26	2.31
Kaiser Permanente Hawaii QUEST	2.58	2.67	2.56+	2.36	2.41
'Ohana Health Plan QUEST	2.29	2.50	2.46	2.19	2.30
UnitedHealthcare Community Plan QUEST	2.28	2.49	2.42+	2.11	2.18

Note: *Based on scores of 2,311 members who completed the CAHPS 5.0H Adult Medicaid Health Plan Survey between February and May 2014. Scores were calculated using the method prescribed by NCQA.*

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Health plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3
Crosswalk of Average Scores to Stars

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.54	2.46	2.40	2.32
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Customer Service	2.61	2.58	2.54	2.48
Getting Needed Care	2.46	2.41	2.37	2.31
Getting Care Quickly	2.49	2.45	2.41	2.37

Note: *Source of star benchmarks:* National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014.* Washington, DC: NCQA, January 30, 2014.

Hawaii Adult Medicaid CAHPS 2014 Results – QExA

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Adult Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to QUEST Expanded Access (QExA) members.[1,2] Survey participants included adult Medicaid members who were 18 years of age or older and enrolled in a QExA health plan from July 1, 2013 through December 31, 2013. The following health plan satisfaction ratings are based on the responses of 1,289 members who completed the survey.[3]

Table 1 shows the overall member satisfaction ratings on each comparable CAHPS measure for the QExA health plans.

Table 1
Overall Member Satisfaction Ratings for QExA Health Plans

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QExA Health Plan					
‘Ohana Health Plan QExA	★	★★★	★★	★	★
UnitedHealthcare Community Plan QExA	★★	★★★★	★	★	★★★★

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 1,289 members who completed the CAHPS 5.0H Adult Medicaid Health Plan Survey between February and May 2014. QExA health plans were compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditaion.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] ‘Ohana Health Plan’s and UnitedHealthcare Community Plan’s QExA ratings are based on the responses of 632 and 657 members who completed a survey, respectively.

Table 2 shows the three-point mean scores on each comparable CAHPS measure for the QExA health plans.

Table 2
Average Ratings and Composite Scores for QExA Health Plans

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QExA Health Plan					
‘Ohana Health Plan QExA	2.28	2.50	2.49	2.25	2.28
UnitedHealthcare Community Plan QExA	2.37	2.54	2.40	2.28	2.45

Note: Based on scores of 1,289 members who completed the CAHPS 5.0H Adult Medicaid Health Plan Survey between February and May 2014. QExA health plans were compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditation.

Health plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3
Crosswalk of Average Scores to Stars

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.54	2.46	2.40	2.32
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Customer Service	2.61	2.58	2.54	2.48
Getting Needed Care	2.46	2.41	2.37	2.31
Getting Care Quickly	2.49	2.45	2.41	2.37

Note: Source of star benchmarks: National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014.* Washington, DC: NCQA, January 30, 2014.

Hawaii Child Medicaid CAHPS 2014 Results – CHIP

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to Hawaii's Children's Health Insurance Program (CHIP) members.[1,2] Survey participants included child Medicaid members who were 17 years of age or younger and enrolled in CHIP from July 1, 2013 through December 31, 2013. The following program satisfaction ratings are based on the responses of 827 parents/caretakers who completed the survey on behalf of a child member.

Table 1 shows the overall member satisfaction ratings on each comparable CAHPS measure for CHIP.

Table 1
Overall Member Satisfaction Ratings for CHIP

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
CHIP	★★★★	★★★★★	★	★	★

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 827 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between February and May 2014 on behalf of their child member. The CHIP population was compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditation.[3]

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 2 shows the three-point mean scores on each comparable CAHPS measure for CHIP.

Table 2
Average Ratings and Composite Scores for CHIP

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
CHIP	2.65	2.69	2.37	2.30	2.51

Note: Based on scores of 827 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between February and May 2014 on behalf of their child member. Scores were calculated using the method prescribed by NCQA.

Ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3
Crosswalk of Average Scores to Stars

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Customer Service	2.63	2.58	2.53	2.50
Getting Needed Care	2.57	2.52	2.46	2.38
Getting Care Quickly	2.69	2.66	2.61	2.54

Note: Source of star benchmarks: National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014.* Washington, DC: NCQA, January 30, 2014.

ELIGIBILITY GROUP	DY 20 (9/1/13 - 12/31/13)	DY 21	DY 22	DY 23	DY 24	DY 25	TOTAL WOW
Children							
Total Expenditure	$ 275,873,745	$ 573,947,734	$ 600,041,186	$ 624,443,477	$ 649,827,615	$ 676,274,607	$ 3,400,408,364
Adults							
Total Expenditure	$ 191,111,710	$ 465,186,205	$ 496,870,037	$ 530,711,855	$ 566,858,640	$ 605,467,382	$ 2,856,205,829
Aged							
Total Expenditure	$ 203,232,947	$ 446,540,636	$ 433,196,293	$ 453,374,628	$ 474,474,118	$ 496,679,227	$ 2,507,497,850
Blind/ Disabled							
Total Expenditure	$ 299,326,737	$ 630,771,390	$ 652,327,333	$ 690,033,884	$ 729,943,185	$ 772,047,004	$ 3,774,449,531
DSH payments							
Total Allotment	$ 48,848,589	$ 99,450,504	$ 101,837,316	$ 51,832,471	$ -	$ -	$ 301,968,880
Total	$ 1,018,393,728	$ 2,215,896,469	$ 2,284,272,165	$ 2,350,396,316	$ 2,421,103,558	$ 2,550,468,220	$ 12,840,530,455

With Waiver

ELIGIBILITY GROUP	DY 20 (9/1/13 - 12/31/13)	DY 21	DY 22	DY 23	DY 24	DY 25	TOTAL WW
Children							
Total Expenditure	$ 101,964,746	$ 173,962,269	$ 205,097,210	$ 213,453,380	$ 222,146,723	$ 309,434,113	$ 1,226,058,441
Adults							
Total Expenditure	$ 147,971,765	$ 158,703,962	$ 148,828,135	$ 159,033,952	$ 169,951,063	$ 181,603,203	$ 966,092,080
Aged							
Total Expenditure	$ 197,411,204	$ 305,114,384	$ 432,695,420	$ 452,824,795	$ 473,873,041	$ 662,382,515	$ 2,524,301,359
Blind/ Disabled							
Total Expenditure	$ 196,673,179	$ 303,548,445	$ 419,731,246	$ 443,678,864	$ 468,983,225	$ 495,672,424	$ 2,328,287,384
UCC Payments							
Total Allotment	$ 45,551,353	$ 70,065,280	$ 76,703,806	$ 38,351,903	$ -	$ -	$ 230,672,342
Excess Hypothetical Groups Cost							
Total Expenditure							$ -
Cost Share							
Total	$ (19,913,325)	$ (29,683,368)	$ (38,800,000)	$ (38,800,000)	$ (38,800,000)	$ (38,800,000)	$ (204,796,693)
Total	$ 669,658,922	$ 981,710,972	$ 1,244,255,817	$ 1,268,542,894	$ 1,296,154,052	$ 1,610,292,255	$ 7,070,614,913

DY BN Savings	$ 348,734,806	$ 1,234,185,497	$ 1,040,016,348	$ 1,081,853,421	$ 1,124,949,505	$ 940,175,965	$ 5,769,915,542
Cummulative Savings	$ 2,773,367,285	$ 4,362,566,438	$ 5,402,582,785	$ 6,484,436,207	$ 7,609,385,712	$ 8,549,561,677	

Hypothetical Test 1 - VIII-like group

Without Waiver

VIII-like group							
Total Expenditure	$ 114,098,289						$ 114,098,289

With Waiver

VIII-like group							
Total Expenditure	$ 114,098,289						$ 114,098,289

Variance	$ -	$ -	$ -	$ -	$ -	$ -	**0.00%**

Hypothetical Test 2 - VIII Group

Without Waiver

VIII group							
Total Expenditure		$ 624,403,801	$ 803,299,898	$ 869,912,439	$ 942,050,803	$ 1,020,178,954	$ 4,259,845,895

With Waiver

QUEST Dashboard Report
SFY 2014 Monthly Trend Analysis

	Jul-13					Aug-13					Sep-13					Oct-13					Nov-13					Dec-13				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United
# Members																														
QUEST Adult	28,778	49,771	6,991	6,493	5,786	27,913	50,680	7,989	6,384	5,481	27,478	50,713	7,920	6,377	5,657	27,808	50,884	7,959	6,812	5,896	28,618	52,800	8,241	7,155	6,547	29,632	54,679	8,471	8,340	7,353
QUEST Keiki	40,634	81,178	15,903	3,702	3,339	39,524	82,230	16,916	3,617	3,115	39,183	82,305	16,783	3,572	3,216	39,017	82,222	16,722	3,647	3,223	39,357	83,123	16,928	3,814	3,437	39,572	83,989	16,961	4,048	3,614
Total	**69,412**	**130,949**	**22,894**	**10,195**	**9,125**	**67,437**	**132,910**	**24,905**	**10,001**	**8,596**	**66,661**	**133,018**	**24,703**	**9,949**	**8,873**	**66,825**	**133,106**	**24,681**	**10,459**	**9,119**	**67,975**	**135,923**	**25,169**	**10,969**	**9,984**	**69,204**	**138,668**	**25,432**	**12,388**	**10,967**
# Network Providers																														
PCPs	568	723	245	661	577	568	722	241	667	618	566	733	238	668	622	579	735	232	666	635	577	746	232	695	644	583	748	229	694	633
Specialists	2,105	2,425	573	1,642	1,523	2,162	2,395	563	1,651	1,560	2,191	2,463	550	1,652	1,560	2,198	2,493	543	1,657	1,570	2,207	2,517	544	1,685	1,584	2,209	2,530	544	1,698	1,624
Behavioral Health	740	1,159	137	458	571	742	1,131	137	462	581	789	1,153	137	470	586	797	1,160	137	487	609	808	1,176	138	491	621	819	1,206	138	503	620
Facilities (Hosp./NF)	25	24	51	51	34	25	24	51	51	34	28	24	51	51	34	29	24	51	51	34	29	24	51	51	34	27	24	51	51	46
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	1,573	1,070	211	1,269	372	1,588	1,061	214	1,275	402	1,536	1,087	213	1,274	407	1,536	1,091	213	1,270	420	1,536	1,106	214	1,285	427	1,536	1,127	214	1,293	796
Total # of providers	**5,011**	**5,401**	**1,217**	**4,081**	**3,077**	**5,085**	**5,333**	**1,206**	**4,106**	**3,195**	**5,110**	**5,460**	**1,189**	**4,115**	**3,209**	**5,139**	**5,503**	**1,176**	**4,131**	**3,268**	**5,157**	**5,569**	**1,179**	**4,207**	**3,310**	**5,174**	**5,635**	**1,176**	**4,239**	**3,719**
Call Center																														
# Member Calls	3,176	9,526	434	1,134	1,293	3,207	11,611	573	1,224	1,308	3,091	8,878	452	1,117	1,198	3,458	10,602	493	1,761	1,314	2,814	8,863	424	1,607	1,227	3,030	7,969	513	1,042	1,290
Avg. time until phone answered	0:00:17	0:00:28	0:00:14	0:00:24	0:00:07	0:00:25	0:01:12	0:00:17	0:00:16	0:05:00	0:00:17	0:30	0:00:13	0:00:26	0:07:00	0:00:43	0:39	0:00:17	0:00:30	0:06:00	0:00:11	2:40	0:00:16	0:00:16	0:05:00	0:00:26	0:39	0:00:20	0:00:15	0:00:07
Avg. time on phone with member	0:03:23	0:03:29	0:03:01	8:29:00	0:06:12	0:03:25	0:03:24	0:03:00	8:07:00	6:04:00	0:03:23	3:34:00	0:02:57	7:31:00	5:48:00	3:24:00	3:26:00	3:04:00	6:33:00	6:06:00	3:30:00	4:01:00	3:09:00	6:23:00	6:33:00	3:41:00	3:54:00	3:10:00	6:32:00	0:06:28
% of member calls abandoned	2.6%	2.47%	2.30%	1.90%	1.1%	5.0%	6:33%	2.10%	1.80%	0.8%	2.6%	2.66%	2.10%	3.00%	1.1%	8.1%	3.74%	2.40%	2.70%	0.8%	2.1%	17.83%	2.30%	1.30%	1.2%	6.4%	3.34%	3.10%	1.40%	1.3%
# Provider Calls	8,528	12,004	N/A	180	1,106	8,657	13,068	N/A	210	958	8,175	13,100	N/A	186	990	9,449	14,296	N/A	191	1,024	7,339	12,545	N/A	189	851	7,627	12,112	N/A	170	851
Avg. time until phone answered	0:00:18	0:27	N/A	0:00:07	0:05:00	0:00:25	0:00:23	N/A	0:00:05	0:05:00	0:00:16	0:26	N/A	0:00:12	0:06:00	0:00:43	0:25	N/A	0:00:10	0:05:00	0:00:11	0:42	N/A	0:00:16	0:05:00	0:00:26	0:16	N/A	0:00:06	0:00:06
Avg. time on phone with provider	0:03:29	0:02:51	N/A	6:00:00	0:06:39	0:03:27	0:02:44	N/A	5:43:00	6:30:00	0:03:23	2:29:00	N/A	6:00:00	6:38:00	3:12:00	9:21:36	N/A	6:12:00	6:34:00	3:54:00	2:12:00	N/A	5:55:00	7:06:00	3:21:00	2:18:00	N/A	5:27:00	0:06:59
% of provider calls abandoned	3.2%	2.42%	N/A	1.1%	5.30%	4.4%	1.64%	N/A	0.5%	4.00%	2.6%	2.82%	N/A	2.7%	4.40%	6.9%	2.56%	N/A	0.0%	2.80%	1.8%	5.27%	N/A	0.0%	3.40%	5.9%	2.11%	N/A	0.0%	4.50%
Medical Claims - Electronic																														
# Submitted, not able to get into system	1,019	5,224	20	259	621	1,161	1,435	14	286	584	992	1,580	31	486	510	1,207	1,654	25	357	514	856	2,303	22	531	414	289	7,640	30	366	516
# Received	32,315	102,444	274	20,879	9,109	28,617	102,070	262	20,862	7,698	34,443	106,323	356	21,010	10,205	39,879	114,560	356	22,217	10,277	37,234	98,384	258	21,994	8,275	36,511	248,632	389	22,769	10,337
# Paid	27,135	61,080	186	13,317	7,952	29,670	75,697	173	18,455	6,600	33,351	72,221	234	14,310	8,500	35,576	92,968	266	17,506	8,622	27,565	75,431	158	18,212	7,058	31,722	206,558	229	17,782	8,771
# In Process	6,802	41,364	79	9,021	712	3,648	26,373	80	6,806	1,213	2,726	34,102	113	8,124	1,435	4,797	21,592	78	7,367	628	9,759	22,953	91	8,856	582	7,938	100,219	151	6,655	18
# Denied	1,497	4,013	9	4,394	1,239	1,959	4,537	9	4,622	942	2,073	4,205	9	5,382	1,394	2,278	6,353	13	5,464	1,816	4,762	4,585	8	5,809	1,770	6,513	19,746	9	7,403	1,428
Avg time for processing claim in days (month to date)	4	7	16	12	10	4	7	15	10	9	4	7	16	10	11	4	7	15	10	12	4	8	14	10	12	7	11	19	18	9
Medical Claims - Paper																														
# Submitted, not able to get into system	951	1,352	177	59	126	401	2,552	119	78	145	403	1,696	190	72	88	409	1,236	150	96	75	330	1,644	165	61	94	112	2,477	172	84	74
# Received	26,362	28,771	2,389	6,606	1,893	25,966	27,823	2,233	5,891	2,841	24,220	27,833	2,184	5,951	1,748	23,745	27,883	2,189	6,264	1,495	21,349	23,906	1,892	5,995	1,871	21,490	55,580	2,206	5,169	1,481
# Paid	22,304	14,028	1,623	3,242	1,555	22,542	18,761	1,478	4,630	2,189	22,940	16,924	1,436	3,688	1,432	21,567	18,800	1,633	4,272	1,151	15,699	14,615	1,160	4,099	1,443	20,714	48,432	1,300	3,552	1,257
# In Process	5,740	14,743	691	3,497	1,284	5,924	9,062	680	2,846	1,284	4,341	10,909	694	3,013	1,544	3,997	9,083	476	2,944	822	8,221	9,291	671	2,535	733	6,755	26,809	855	2,669	9
# Denied	3,125	1,071	75	1,619	296	3,062	2,068	75	1,912	609	2,923	1,774	54	2,096	304	2,513	1,945	79	2,057	331	1,678	1,463	62	2,735	422	2,157	7,347	51	1,656	358
Avg time for processing claim in days (month-to-date)	6	10	16	16	15	6	10	15	14	13	6	9	16	15	18	8	11	15	14	18	7	11	14	18	18	9	15	19	16	14
Prior Authorization (PA)- Electronic																														
# Received	66	252	102	8	0	93	265	103	13	4	106	308	123	7	4	148	98	50	6	9	100	172	118	4	3	99	153	142	8	4
# In Process	8	73	0	0	0	3	78	0	0	0	11	99	1	0	0	9	80	0	1	4	1	46	0	0	2	13	33	0	0	3
# Approved	57	240	99	8	0	89	213	99	13	4	95	253	118	7	4	137	202	41	5	4	96	162	117	4	1	84	168	140	8	1
# Denied	1	42	3	0	0	1	47	4	0	0	0	35	4	0	0	2	38	9	0	0	3	44	1	0	0	2	33	2	0	0
Avg time for PA in days (month to date)	4	11	1	7	0	5	9	3	4	7	6	7	3	0	7	5	12	3	7	3	7	11	3	11	2	7	12	3	0	2
Prior Authorization (PA)- Paper and Telephone																														
# Received	2973	57	1	201	785	2724	72	0	190	836	3,189	241	1	205	696	3,527	1,064	1	209	887	2,572	1,088	2	224	840	3,170	1,124	4	242	806
# In Process	205	1	0	2	63	369	0	0	4	11	449	0	0	5	16	446	13	0	11	55	17	0	0	7	86	853	0	0	49	121
# Approved	2741	45	0	197	712	2347	58	0	185	791	2,721	165	0	198	665	3,051	888	0	198	815	2,529	969	0	217	737	2,291	908	0	190	668
# Denied	27	11	1	2	10	8	15	0	1	34	19	76	1	2	15	28	163	1	0	17	26	130	2	0	17	26	197	4	3	17
Avg time for PA in days (month-to-date)	4	0	14	7	4	4	3	0	7	8	5	0	14	4	6	4	1	10	3	4	5	1	13	3	3	5	1	10	6	2
# Non-Emergency Transports																														
Ground	421	559	31	223	437	481	432	28	232	437	419	485	18	314	368	449	678	53	308	444	405	566	41	279	584	324	523	84	349	612
Air	554	566	1	73	62	575	439	1	71	36	478	496	0	72	49	522	711	0	81	53	457	583	0	65	49	444	560	0	73	67
* round trip																														
# Member Grievance																														
# Received	5	5	7	1	4	15	15	6	8	3	29	10	6	2	5	15	10	8	5	2	8	7	17	5	6	14	8	10	6	6
# Resolved	5	3	7	6	2	12	11	3	2	4	10	14	6	6	4	30	12	4	3	5	14	6	21	4	1	9	8	9	6	7
# Outstanding	4	4	1	0	4	7	8	4	6	3	26	4	0	2	4	10	2	4	4	1	4	3	4	5	6	9	5	5	5	5
# Provider Grievance																														
# Received	1	1	0	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	2	2	0	0	2	0	0	0	1	0
# Resolved	0	1	0	0	0	0	1	0	0	0	3	0	0	2	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	1
# Outstanding	1	1	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	1	1
# Member Appeals																														
# Received	1	18	1	0	0	1	14	1	0	0	2	60	0	1	0	1	72	0	0	1	1	42	0	1	0	2	25	1	0	0
# Resolved	4	15	1	0	0	2	14	2	0	0	1	33	1	0	0	1	70	0	0	1	2	46	0	1	0	2	43	2	0	0
# Outstanding	1	10	1	0	0	0	10	1	0	0	1	37	0	1	0	1	39	0	1	0	0	35	0	1	0	0	18	1	0	0
# Provider Appeals																														
# Received	0	1	0	13	13	0	5	1	12	6	3	0	0	15	9	0	1	0	10	19	0	2	0	12	12	0	0	0	12	17
# Resolved	0	2	0	1	10	0	2	0	7	9	1	4	1	11	3	1	3	0	10	19	0	1	0	14	12	0	0	0	3	20
# Outstanding	0	4	0	19	6	0	7	1	24	3	2	3	0	28	9	1	1	0	28	9	0	2	0	26	9	0	2	0	32	6
Utilization - based on Auth (A) or Claims (C)																														
Inpatient Acute Admits (A) - per 1,000	67	91	3	218	157	81	98	4	244	209	75	90	4	176	189	79	97	4	173	207	80	90	2	130	164	72	111	3	144	135
Inpatient Acute Days (A) - per 1,000	261	385	11	937	552	363	556	14	970	869	325	524	15	785	695	316	552	13	645	756	304	539	9	319	753	257	528	12	588	632
Inpatient Acute Psych Admits (A)- per 1,000	5	1	1	24	11	5	1	1	25	9	8	1	0	35	9	8	1	0	23	14	7	1	0	9	9	7	1	1	19	5
Inpatient Acute Psych Days (A)- per 1,000	35	3	3	104	60	27	2	5	152	38	37	3	6	111	41	27	7	5	101	60	21	7	2	21	38	29	7	7	56	21
Readmissions within 30 days (A)	37	119	0	21	10	38	132	0	18	15	39	146	0	17	12	33	151	0	22	21	35	101	0	10	4	22	159	0	20	8
Waitlisted Days (A) - per 1,000	35	5	1	0	0	30	12	0	0	0	23	8	1	0	0	30	7	1	0	0	31	11	1	20	0	25	9	1	13	0
ER Visits (C) - per 1,000	545	442	18	753	712	524	472	20	743	759	546	463	19	714	762	542	475	19	597	573	550	467	18	742	335	539	503	19	620	587
# Prescriptions (C) - per 1,000	7,429	9,133	588	8,490	7,411	7,295	9,305	600	9,153	7,031	7,167	8,923	585	9,432	7,047	6,393	9,527	618	9,702	7,595	7,122	8,964	585	8,927	6,873	6,835	9,355	631	8,572	6,919

Legend:
ER= Emergency Room
Hosp= Hospital
PCP= Primary Care Provider
Psych= Psychiatric

Many health plans report utilization or frequency of services on a per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	July '13		August '13		September '13		October '13		November '13		December '13	
	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United
# Members												
Medicaid	9,754	6,717	9,664	6,785	9,668	6,888	9,803	6,894	10,013	6,874	9,861	6,867
Duals	14,905	14,751	14,980	14,782	14,859	14,925	14,892	14,863	14,980	15,147	15,268	15,187
Total Members	**24,659**	**21,468**	**24,644**	**21,567**	**24,527**	**21,813**	**24,695**	**21,757**	**24,993**	**22,021**	**25,129**	**22,054**
# Network Providers												
PCPs (incl FQHC less est 100 FQHC PCPs)	796	1,024	802	1,091	800	1,085	802	1,094	805	1,105	804	834
Specialists	2,148	1,864	2,167	1,926	2,168	1,918	2,176	1,940	2,184	1,948	2,196	2,360
Facilities (Hosp./NF)	63	58	63	58	63	58	63	58	63	58	63	46
Foster Homes (FH) (CCFHH only; no E-ARCH)	935	1,022	948	1,022	942	1,023	971	1,024	972	1,025	978	1,163
HCBS Providers (All LTC, except CCFHH and NF)	155	223	155	231	154	240	155	245	155	257	155	244
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,542	1183	1,547	1201	1,549	1207	1,550	1232	1,569	1252	1,578	676
Total # of providers	**5,639**	**5,374**	**5,682**	**5,529**	**5,676**	**5,531**	**5,717**	**5,593**	**5,748**	**5,645**	**5,774**	**5,323**
Call Center												
# Member Calls	5,537	5,782	5,356	5,370	4,965	5,385	10,605	5,664	8,315	4,469	8,250	4,362
Avg. time until phone answered	0:00:28	00:07	0:00:22	00:08	0:00:34	00:11	0:00:38	00:08	0:00:25	00:07	0:00:19	00:07
Avg. time on phone with member	8:14	6:50	8:55	7:04	8:42	7:09	6:44	7:01	6:29	7:07	0:06	7:03
% of member calls abandoned	3.4%	1.4%	2.5%	1.7%	4.0%	2.0%	4.7%	2.0%	3.8%	1.2%	3.0%	1.6%
# Provider Calls	4,891	2,272	4,960	2,298	4,781	2,090	5,438	2,395	4,113	1,956	4,294	1,753
Avg. time until phone answered	0:00:45	00:08	0:00:34	00:08	0:00:47	00:12	0:00:46	00:09	0:00:35	00:08	0:00:25	00:07
Avg. time on phone with provider	7:52	0:07	8:07	0:07	7:45	0:07	7:38	0:07	7:39	0:08	0:07	7:44
% of provider calls abandoned	3.2%	0.8%	2.7%	1.0%	5.0%	2.4%	4.1%	1.3%	2.9%	0.7%	1.7%	1.3%
Medical Claims- Electronic												
# Submitted, not able to get into system	3,572	1,924	2,378	1,785	2,995	2,664	2,503	2,844	3,871	2,539	2,980	2,638
# Received	129,946	49,937	129,138	43,944	119,989	53,294	139,104	57,016	138,592	50,796	132,925	52,771
# Paid	81,576	38,572	90,870	36,474	72,655	43,044	84,949	43,886	79,126	46,778	81,285	40,713
# In Process	72,610	4,970	63,371	7,283	62,926	7,485	57,277	3,306	81,843	787	64,632	813
# Denied	52,573	10,461	47,456	5,830	47,799	8,612	59,596	14,068	43,969	14,376	62,213	11,558
Avg time for processing claim in days	15.6	14	13.7	14	12.9	19	11.6	18	13.1	12	17.234114	9
* unable to break out (month to date)												
Medical Claims- Paper												
# Submitted, not able to get into system	208	752	210	813	149	730	226	642	234	629	310	547
# Received	66,014	14,217	61,504	17,974	55,640	14,592	62,437	12,835	60,099	12,580	48,059	10,954
# Paid	23,188	11,154	34,142	12,854	26,603	10,683	26,110	9,592	22,176	10,167	22,085	8,228
# In Process	43,302	9,563	39,307	16,587	36,324	6,521	34,935	7,140	37,739	1,755	30,527	1,801
# Denied	24,777	2,713	31,370	5,958	32,140	2,068	37,868	4,652	33,649	4,722	30,119	3,321

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	July '13		August '13		September '13		October '13		November '13		December '13	
	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United
Avg time for processing claim in days (month-to-date)	19.4	20	17.0	18	19.2	24	14.4	22	19.1	17	20.1	14
Prior Authorization (PA)- Electronic												
# Received											61	35
# In Process											0	8
# Approved											61	27
# Denied											0	0
Avg time for PA in days (month to date)											1	6
Prior Authorization (PA)- Paper and Telephone												
# Received											1032	3189
# In Process											155	107
# Approved											855	2848
# Denied											22	234
Avg time for PA in days (month-to-date)											6	2
# Non-Emergency Transports												
Ground	7,979	15,825	7,935	15,667	7,430	15,030	7,934	16,063	7,542	15,208	7,705	16,129
Air	496	402	527	391	512	347	632	395	459	302	547	288
* round trip												
# Member Grievance												
# Received	39	37	55	48	45	49	50	53	53	55	57	51
# Resolved	39	35	47	47	43	58	51	46	39	48	62	62
# Outstanding	27	23	35	24	37	15	36	22	50	29	45	18
# Provider Grievance												
# Received	2	0	7	1	2	0	3	2	1	1	4	5
# Resolved	4	0	0	0	5	1	5	0	2	0	2	2
# Outstanding	1	0	8	1	5	0	3	2	2	3	4	6
# Member Appeals												
# Received	4	3	1	3	3	5	2	6	5	1	5	0
# Resolved	6	4	2	4	1	2	5	3	2	4	7	3
# Outstanding	3	1	2	0	4	3	1	6	4	3	2	0
# Provider Appeals												
# Received	29	45	37	46	21	49	144	52	32	47	124	76
# Resolved	21	52	4	48	30	28	32	71	59	25	135	65
# Outstanding	29	33	62	31	53	52	165	33	138	55	143	66

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	July '13		August '13		September '13		October '13		November '13		December '13	
	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United	'Ohana	United
Utilization - based on Auth (A) or Claims (C)												
Inpatient Acute Admits * (A) - per 1,000	296	228	278	263	260	226	279	191	267	246	301	252
Inpatient Acute Days * (A) - per 1,000	1,925	1,407	1,969	1,471	1,549	1,073	1,484	1,251	1,392	1,222	1,025	1,558
Readmissions within 30 days* (A)	74	37	76	45	53	47	71	18	76	49	46	37
ER Visits * (C) - per 1,000**	1,094	936	1,116	1,038	1,138	952	995	924	1,129	1,957	1,135	2,050
# Prescriptions (C) - per 1,000	22,052	19,742	21,878	19,572	20,076	18,110	21,683	19,369	21,424	19,206	20,618	19,902
Waitlisted Days * (A) - per 1,000	354	94	320	31	272	45	242	40	418	39	387	35
NF Admits * (A)	1	0	1	0	0	0	3	2	1	2	3	2
# Members in NF (non-Medicare paid days) (C)**	1,462	1,247	1,448	1,271	1,380	1,264	1,288	1,287	1,406	1,256	1,364	1,217
# Members in HCBS **(C)- note: member can be included in more than one category listed below	2,300	2,537	2,239	2,664	2,259	2,629	2,130	2,613	2,274	2,596	2,209	2,547
# Members in FH **(C)	706	1,043	701	1,042	694	1,037	655	1,023	706	1,038	683	1,021
# Members in Self-Direction **(C)	892	936	848	957	873	935	849	928	873	910	849	895
# Members receiving other HCBS **(C)	1,408	839	1,391	2,510	1,386	2,469	1,281	2,464	1,401	1,008	1,360	963
(* non-Medicare) (**lag in data of two months)												

Legend:
ER= Emergency Room
FH=Foster Home
HCBS= Home and Community Based Services
Hosp= Hospital
NF=Nursing Facility
PCP= Primary Care Provider
CMS 1500- physicians, case management agencies, RACCP homes, home health, etc.
CMS UB04- nursing facilities, FQHC, hospitals

Many health plans report utilization or frequency of services on a per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

* Duplicates included

QUEST Dashboard Report
SFY 2014 Monthly Trend Analysis

	Jan-14					Feb-14					Mar-14					Apr-14					May-14					Jun-14				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members																														
QUEST Adult	30,531	57,394	8,789	9,043	8,196	31,304	59,632	9,006	9,827	8,728	32,713	62,153	9,177	10,859	9,757	32,167	64,281	9,316	11,119	10,112	31,854	64,619	9,158	10,995	10,004	30,751	63,709	8,980	10,858	9,931
QUEST Keiki	39,941	85,289	17,179	4,304	3,851	40,338	86,241	17,334	4,277	3,954	40,846	87,098	17,468	4,732	4,252	40,817	87,802	17,481	4,875	4,369	39,358	86,402	17,024	4,838	4,320	37,396	84,512	16,563	4,764	4,288
Total	**70,472**	**142,683**	**25,968**	**13,347**	**12,047**	**71,642**	**145,873**	**26,340**	**14,104**	**12,682**	**73,559**	**149,251**	**26,645**	**15,591**	**14,009**	**72,984**	**152,083**	**26,797**	**15,994**	**14,481**	**71,212**	**151,021**	**26,182**	**15,833**	**14,324**	**68,458**	**148,221**	**25,543**	**15,622**	**14,219**
# Network Providers																														
PCPs	314	747	229	573	635	316	759	229	591	627	320	768	231	582	629	549	766	229	584	636	550	757	229	584	635	554	752	215	586	634
PCPs - #in Clinics (ex. FQHC, CHC, etc.)																														
Specialists	2,079	2,554	531	1,708	1,633	2,098	2,463	525	1,781	1,557	2,093	2,459	525	1,877	1,556	2,092	2,503	531	1,872	1,561	2,014	2,520	531	1,825	1,549	2,085	2,543	531	1,792	1,548
Behavioral Health	609	1,219	137	505	641	615	1,190	137	521	646	625	1,190	147	523	655	642	1,200	145	532	668	645	1,222	145	533	684	646	1,239	147	547	671
Facilities (Hosp./NF)	33	24	52	51	46	33	24	52	51	46	33	24	52	51	46	34	24	52	51	46	34	24	52	51	46	35	24	52	51	46
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	1,424	1,118	321	1,308	800	1,439	1,105	321	1,325	931	1,460	1,108	321	1,320	932	1,471	1,119	321	1,317	982	1,478	1,122	321	1,292	1,028	1,476	1,134	329	1,311	1,029
Total # of providers	**4,459**	**5,662**	**1,270**	**4,145**	**3,755**	**4,501**	**5,540**	**1,264**	**4,269**	**3,807**	**4,531**	**5,549**	**1,276**	**4,353**	**3,818**	**4,788**	**5,612**	**1,278**	**4,356**	**3,893**	**4,721**	**5,645**	**1,278**	**4,245**	**3,942**	**4,796**	**5,692**	**1,274**	**4,287**	**3,928**
Call Center																														
# Member Calls	3,609	10,521	587	2,357	1,550	3,494	10,105	378	2,168	1,405	3,554	10,829	436	2,407	1,497	4,240	14,594	460	2,462	1,621	4,157	15,051	394	2,194	1,723	4,571	14,572	460	2,549	892
Avg. time until phone answered	0:00:23	0:34:00	0:00:18	0:00:22	0:00:08	0:00:13	0:22:00	0:00:12	0:00:23	0:00:11	0:00:23	0:26:00	0:00:11	0:00:09	0:00:11	0:00:14	0:27:00	0:00:10	0:00:11	0:00:07	0:00:17	1:16:00	0:00:13	0:00:12	0:00:10	0:00:23	1:07:00	0:00:13	0:00:10	00:05
Avg. time on phone with member	3:40:00	3:51:00	3:10:00	0:06:32	0:05:42	3:39:00	3:53:00	3:12:00	0:06:23	0:05:38	3:22:00	3:38:00	3:10:00	0:06:00	0:05:41	3:11:00	2:50:00	3:07:00	0:06:02	0:04:42	3:06	7:55:12	3:06:00	0:07:07	0:04:30	3:12	2:47:00	3:08:00	0:06	10:52
% of member calls abandoned	3.5%	3.08%	3.00%	1.87%	1.5%	2.1%	2.15%	2.70%	2.90%	3.6%	3.9%	2.33%	2.80%	2.20%	3.6%	2.2%	2.42%	2.60%	2.60%	1.6%	2.6%	7.86%	2.60%	2.32%	2.1%	5.6%	7.99%	2.90%	3.6%	0.8%
# Provider Calls	8,524	14,051	N/A	216	1,078	7,348	13,198	N/A	212	1,022	8,359	12,835	N/A	219	1,079	9,033	15,118	N/A	248	1,000	8,699	16,276	N/A	231	1,224	8,492	12,085	N/A	233	337
Avg. time until phone answered	0:00:23	0:17:00	N/A	0:00:06	00:06	0:00:14	0:25:00	N/A	0:00:06	00:07	0:00:21	0:22:00	N/A	0:00:06	00:07	0:00:15	0:25:00	N/A	0:00:05	00:06	0:00:16	0:29:00	N/A	0:00:06	00:08	0:00:23	0:25:00	N/A	0:00:07	00:04
Avg. time on phone with provider	3:25:00	2:20:00	N/A	0:05:26	0:06:34	3:25:00	2:23:00	N/A	0:06:27	0:05:52	3:30:00	2:56:00	N/A	0:06:27	0:05:43	3:03:00	2:33:00	N/A	0:06:16	0:05:54	3:07	2:03:00	N/A	0:06:51	0:05:53	3:18	2:05:00	N/A	0:07	09:07
% of provider calls abandoned	4.68%	2.28%	N/A	0.46%	6.00%	3.00%	3.00%	N/A	0.47%	14.00%	4.60%	2.33%	N/A	0.0%	10.80%	3.30%	3.23%	N/A	1.60%	5.10%	3.4%	4.51%	N/A	0.0%	7.10%	5.5%	3.08%	N/A	2.1%	0.6%
Medical Claims - Electronic																														
# Submitted, not able to get into system	987	8,049	8	352	547	1,016	6,080	13	313	552	1,195	8,468	14	382	656	1,467	9,745	30	342	652	1,180	6,993	5	376	703	1,571	11,957	8	375	680
# Received	37,222	249,948	232	10,021	10,953	34,437	233,249	267	9,483	11,051	38,066	265,162	245	11,315	13,133	38,677	272,017	254	11,872	13,054	40,689	276,847	138	13,311	14,061	36,540	268,834	243	12,193	13,619
# Paid	34,611	240,616	156	8,604	8,850	35,938	217,298	165	8,640	9,307	37,613	230,225	154	11,995	10,752	30,286	229,942	150	10,365	11,257	37,923	288,823	86	12,168	12,354	33,509	230,230	156	10,483	11,308
# In Process	8,431	87,950	71	546	33	15,736	88,268	95	484	39	2,953	106,227	86	198	44	9,510	129,878	97	133	57	4,543	96,379	89	310	69	5,005	116,717	159	541	78
# Denied	2,119	21,600	4	737	1,538	1,786	15,418	6	742	1,646	2,625	16,905	5	1,033	1,720	1,903	18,253	6	929	1,805	2,766	21,426	3	1,170	2,023	2,459	18,141	4	1,008	1,903
Avg time for processing claim in days (month to date)	7	11	21	9	8	6	11	19	9	8	4	11	14	8	8	4	11	13	7	9	4	11	13	7	8	4	12	14	8	8
Medical Claims - Paper																														
# Submitted, not able to get into system	469	1,848	86	68	70	1,019	1,392	105	87	84	528	1,670	138	126	93	448	2,965	301	293	93	468	4,216	99	303	85	486	3,525	94	294	86
# Received	21,799	59,221	2,342	2,795	1,405	21,017	54,983	2,159	3,283	1,689	23,780	61,074	2,472	3,992	1,867	20,305	52,912	2,563	3,094	1,862	20,045	42,821	2,622	3,279	1,718	21,757	35,374	2,789	3,244	1,730
# Paid	19,731	49,698	1,579	2,320	1,068	18,486	50,875	1,338	3,095	1,377	22,109	49,031	1,556	3,459	1,430	18,057	48,689	1,521	2,976	1,277	17,754	48,238	1,632	2,704	1,518	19,814	38,742	1,786	2,527	1,234
# In Process	6,328	28,624	719	506	14	14,688	27,219	771	556	15	6,137	32,946	865	151	13	5,973	30,520	980	55	14	5,857	25,214	1,692	285	19	5,273	25,244	1,828	408	18
# Denied	2,068	7,506	45	416	266	1,844	5,885	51	565	349	2,499	7,065	51	604	363	2,313	7,019	63	494	513	2,291	6,318	60	475	317	2,548	5,582	41	543	307
Avg time for processing claim in days (month-to-date)	10	15	21	13	10	9	14	19	14	11	8	14	14	9	10	7	16	13	8	10	7	18	13	7	14	8	21	14	9	12
Prior Authorization (PA)- Electronic																														
# Received	115	239	122	8	17	124	226	100	11	1	115	234	119	2	9	110	298	121	2	15	105	298	378	10	4	91	262	109	14	5
# In Process	21	65	0	0	6	21	99	0	0	0	21	102	0	0	1	16	129	0	0	2	11	94	0	0	0	13	98	0	0	1
# Approved	94	194	120	8	11	103	170	99	11	1	93	199	114	2	8	93	222	116	2	11	93	276	375	9	4	78	215	105	14	4
# Denied	0	34	2	0	0	0	22	1	0	0	1	32	5	0	0	1	49	5	0	2	1	57	3	1	0	0	43	4	0	0
Avg time for PA in days (month to date)	6	9	1	0	2	6	10	3	3	7	5	12	3	1	6	7	13	4	1	5	7	11	3	0	1	6	10	5	1	4
Prior Authorization (PA)- Paper and Telephone																														
# Received	3,599	877	2	194	1,039	3,563	861	1	184	847	3,602	893	2	191	1,000	3,298	808	2	187	1,179	3,212	717	4	199	1,127	3,004	703	2	182	1,117
# In Process	815	58	0	11	136	859	50	0	19	80	804	62	0	15	97	694	22	0	3	83	545	4	0	0	9	640	0	0	2	29
# Approved	2,760	714	0	181	877	2,686	691	0	165	740	2,775	681	0	175	883	2,585	664	0	182	1,066	2,650	571	0	195	1,084	2,350	542	0	178	1,058
# Denied	24	177	2	2	26	18	178	1	5	27	23	200	2	1	20	19	184	2	2	30	17	164	4	4	34	14	165	2	2	30
Avg time for PA in days (month-to-date)	5	1	13	5	3	5	7	1	5	3	4	1	1	3	3	4	3	14	3	3	4	1	13	4	3	5	0	9	4	3
# Non-Emergency Transports																														
Ground	465	607	78	429	667	362	519	28	488	553	443	611	37	489	683	451	635	46	600	680	527	531	24	555	870	583	604	27	520	351
Air	504	650	0	72	66	383	495	0	55	45	430	565	4	91	64	477	620	6	106	61	428	519	0	109	81	469	648	0	109	21
* round trip																														
# Member Grievance																														
# Received	10	8	6	3	3	12	7	5	8	4	33	9	8	7	3	17	6	6	4	3	17	5	10	8	4	8	8	8	8	4
# Resolved	16	7	7	5	6	11	7	8	6	2	14	7	8	3	5	34	10	6	8	3	21	4	10	4	2	10	7	5	8	4
# Outstanding	3	6	4	1	2	6	6	1	3	4	25	8	1	7	2	8	4	1	3	2	5	5	1	7	4	3	6	4	7	4
# Provider Grievance																														
# Received	0	1	0	0	1	0	1	0	0	0	2	1	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0
# Resolved	0	0	0	2	2	0	1	0	0	0	0	1	0	0	0	0	1	0	0	0	2	2	0	0	0	0	1	0	0	0
# Outstanding	0	1	0	0	0	0	1	0	0	0	2	1	0	0	0	2	2	0	0	0	0	1	0	0	0	0	0	0	0	0
# Member Appeals																														
# Received	2	26	2	1	0	2	27	2	0	4	1	43	2	0	1	2	38	0	0	3	0	31	0	1	2	1	28	5	1	2
# Resolved	0	32	1	0	0	3	25	2	1	0	1	41	3	0	4	1	30	1	0	1	1	31	0	0	3	1	36	1	1	2
# Outstanding	2	12	2	1	0	1	14	2	0	4	1	16	1	0	1	2	24	0	0	3	1	24	0	1	2	1	16	4	1	2
# Provider Appeals																														
# Received	0	2	0	10	16	0	3	0	9	7	0	3	0	10	25	1	2	0	14	15	0	1	0	6	21	0	3	0	11	15
# Resolved	0	2	0	20	12	0	0	0	9	15	0	3	0	3	6	0	4	0	11	27	1	2	0	12	20	0	0	0	20	13
# Outstanding	0	2	0	21	10	0	5	0	21	2	0	5	0	28	21	1	3	0	23	9	0	2	0	25	10	0	5	0	16	12

QUEST Dashboard Report
SFY 2014 Monthly Trend Analysis

	Jan-14					Feb-14					Mar-14					Apr-14					May-14					Jun-14				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	UNITED
Utilization - based on Auth (A) or Claims (C)																														
Inpatient Acute Admits (A) - per 1,000	66	111	3	161	142	68	103	2	147	114	71	131	2	124	99	73	125	2	118	117	71	130	2	121	126	69	124	2	143	100
Inpatient Acute Days (A) - per 1,000	302	513	14	679	740	302	455	10	709	685	247	557	13	489	415	294	524	12	638	812	308	595	12	561	611	302	499	9	797	621
Inpatient Acute Psych Admits (A)- per 1,000	7	1	0	14	11	7	1	0	19	5	10	1	0	20	6	5	1	0	12	9	6	1	0	17	10	7	1	0	14	6
Inpatient Acute Psych Days (A)- per 1,000	26	7	1	35	51	26	7	4	67	30	41	8	3	49	24	25	7	1	39	33	20	7	3	40	73	30	6	3	41	29
Readmissions within 30 days (A)	25	191	0	26	8	25	169	0	28	11	24	253	0	21	12	26	300	0	22	9	23	307	0	28	4	32	249	0	26	11
Waitlisted Days (A) - per 1,000	37	11	0	0	0	37	11	0	0	16	25	11	0	0	11	40	8	1	0	12	46	12	0	0	10	50	7	0	0	0
ER Visits (C) - per 1,000	565	494	19	707	508	574	447	20	664	500	569	482	19	682	584	505	432	19	632	577	556	463	19	657	517	520	470	19	702	556
# Prescriptions (C) - per 1,000	7,432	9,798	677	8,572	7,861	7,432	9,034	623	8,216	7,303	7,845	9,556	683	8,238	7,573	7,911	9,439	664	8,519	7,818	7,964	9,681	673	8,767	8,634	7,013	9,293	630	8,298	8,338

Legend:
ER= Emergency Room
Hosp= Hospital
PCP= Primary Care Provider
Psych= Psychiatric

Many health plans report utilization or frequency of services on a per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

Attachment E

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	January '14		February '14		March '14		April '14		May '14		June '14	
	Ohana	United	Ohana	United	Ohana	United	Ohana	United	Ohana	United	Ohana	United
# Members												
Medicaid	9,953	6,919	10,115	6,936	10,254	6,942	10,419	7,006	10,426	7,060	10,548	7,061
Duals	15,348	15,440	15,298	15,584	15,252	15,671	15,238	15,803	15,391	15,902	15,277	15,933
Total Members	**25,301**	**22,359**	**25,413**	**22,520**	**25,506**	**22,613**	**25,657**	**22,809**	**25,817**	**22,962**	**25,825**	**22,994**
# Network Providers												
PCPs	541	836	546	816	553	818	559	825	556	820	557	813
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)												
Specialists	2209	2,389	2230	2,292	2212	2,299	2212	2,320	2187	2,335	2141	2,324
Facilities (Hosp./NF)	63	46	63	46	63	46	63	46	63	46	63	46
Foster Homes (FH) (CCFHH only; no E-ARCH)	979	1,173	990	998	994	1,000	1000	1,003	999	1,010	1011	1,024
HCBS Providers (All LTC, except CCFHH and NF)	156	247	157	278	156	282	156	284	156	288	157	288
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,596	684	1,613	982	1,612	982	1,618	1016	1,590	1,050	1,622	1,054
Total # of providers	**5,544**	**5,375**	**5,599**	**5,412**	**5,590**	**5,427**	**5,608**	**5,494**	**5,551**	**5,549**	**5,551**	**5,549**
Call Center												
# Member Calls	10,490	5,276	7,940	4,778	8,698	4,254	9,467	4,317	8,693	4,562	9,697	3,470
Avg. time until phone answered	0:00:26	00:11	0:00:27	00:14	0:00:11	00:08	0:00:12	00:08	0:00:12	00:11	0:00:11	00:12
Avg. time on phone with member	0:06	0:06	0:06	0:06	0:06	0:07	0:06	0:07	0:07	07:45	0:06	11:59
% of member calls abandoned	5%	3.4%	5%	5.0%	2%	1.6%	3%	1.7%	3%	3.1%	4%	1.0%
# Provider Calls	4,520	2,347	4,085	2,303	4,314	1,884	4,482	1,940	4,213	2,054	4,609	2,454
Avg. time until phone answered	0:00:33	00:11	0:00:28	00:15	0:00:17	00:09	0:00:16	00:08	0:00:26	00:10	0:00:30	00:10
Avg. time on phone with provider	0:08	0:07	0:07	0:07	0:10	0:07	0:07	0:08	0:07	09:09	0:08	11:59
% of provider calls abandoned	3%	2.9%	3%	3.6%	2%	1.3%	2%	1.0%	2%	2.3%	3%	0.8%
Medical Claims- Electronic												
# Submitted, not able to get into system	3,073	2,748	2,233	2,667	2,629	2,974	2,401	2,240	2,109	2,139	2,085	2,195
# Received	51,397	54,970	49,927	53,344	56,858	58,484	59,366	44,802	59,116	42,799	53,845	43,913
# Paid	43,319	42,336	39,857	40,167	56,930	47,367	46,241	39,863	47,471	31,713	40,387	32,642
# In Process	9,324	985	12,083	807	5,985	828	6,671	853	6,349	841	7,318	881
# Denied	4,816	10,963	4,494	10,938	5,642	12,375	7,860	11,999	6,505	9,448	7,193	10,702
Avg time for processing claim in days	12	9	10	10	9	9	7	10	8	9	8	11
* unable to break out (month to date)												
Medical Claims- Paper												
# Submitted, not able to get into system	232	459	322	479	447	514	1,155	884	2,875	1,086	1,111	1,265
# Received	17,442	9,196	18,985	9,588	22,204	10,287	17,435	17,693	15,930	21,723	17,378	25,300
# Paid	13,407	7,785	14,339	6,376	18,311	8,113	13,207	11,789	10,637	15,382	10,106	16,868
# In Process	6,250	1,778	6,422	1,851	3,215	1,763	2,079	1,773	3,033	1,811	3,939	1,872
# Denied	3,616	2,853	3,744	2,061	5,073	2,148	4,360	4,810	3,603	5,809	4,057	6,689

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Avg time for processing claim in days (month-to-date)	17	13	19	15	13	15	7	11	8	8	10	8
Prior Authorization (PA)- Electronic												
# Received	77	63	28	58	30	62	50	49	30	47	52	32
# In Process	2	24	2	8	0	12	0	11	1	2	2	1
# Approved	75	34	26	42	30	48	48	37	27	44	49	31
# Denied	0	5	0	8	0	2	2	1	2	1	1	0
Avg time for PA in days (month to date)	1	4	0	6	0	5	0	5	1	5	1	5
Prior Authorization (PA)- Paper and Telephone												
# Received	805	3,073	672	3,127	734	3,774	678	3,846	711	4,171	677	4,316
# In Process	18	175	28	132	26	197	30	242	15	118	14	149
# Approved	773	2,662	635	2,739	702	3,300	637	3,350	658	3,787	631	3,930
# Denied	14	236	9	256	6	277	11	254	38	266	32	237
Avg time for PA in days (month-to-date)	5	3	5	3	4	3	4	3	4	4	5	2
# Non-Emergency Transports												
Ground	9,325	16,181	8,567	14,445	8,453	15,107	9,552	15,778	9,583	16,415	8,941	7,349
Air	635	329	505	289	530	364	513	395	488	333	571	112
* round trip												
# Member Grievance												
# Received	74	58	62	59	59	46	64	65	74	81	99	68
# Resolved	70	55	77	63	51	57	54	37	58	72	76	82
# Outstanding	49	21	34	17	42	6	52	34	68	43	91	29
# Provider Grievance												
# Received	2	0	3	1	1	2	2	5	4	0	3	0
# Resolved	4	2	4	4	2	1	1	2	1	2	1	3
# Outstanding	3	4	2	1	1	2	2	5	5	3	7	0
# Member Appeals												
# Received	2	5	5	5	5	21	7	17	6	17	1	3
# Resolved	3	0	2	5	5	7	5	22	8	11	1	20
# Outstanding	1	5	4	5	4	19	6	14	4	20	4	3
# Provider Appeals												
# Received	73	35	10	58	31	60	13	40	28	60	13	55
# Resolved	110	82	83	51	4	48	2	58	27	45	18	53
# Outstanding	79	19	6	26	33	38	44	20	45	35	40	37

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Utilization - based on Auth (A) or Claims (C)												
Inpatient Acute Admits * (A) - per 1,000	297	225	253	198	290	258	254	205	287	218	301	216
Inpatient Acute Days * (A) - per 1,000	1,659	1,601	1,236	1,174	1,364	1,389	937	1,494	1,848	1,402	1,690	1,510
Readmissions within 30 days* (A)	75	51	66	17	68	33	62	25	64	26	72	26
ER Visits * (C) - per 1,000**	1,047	1,703	1,063	1,868	1,108	2,039	994	1,922	1,133	2,261	1,107	837
# Prescriptions (C) - per 1,000	21,012	20,362	18,841	18,468	20,550	19,845	20,477	19,520	20,773	19,708	19,080	19,304
Waitlisted Days * (A) - per 1,000	373	36	414	62	227	71	168	77	155	83	201	75
NF Admits * (A)	6	4	1	0	0	1	3	4	2	1	3	2
# Members in NF (non-Medicare paid days) (C)**	1,398	1,186	1,373	1,255	1,410	1,234	1,390	1,182	1,429	1,197	1,417	1,211
# Members in HCBS **(C)- note: member can be included in more than one category listed below	2,235	2,535	2,224	2,595	2,300	2,606	2,258	2,570	2,235	2,552	2,252	2,522
# Members in FH **(C)	669	1,039	683	1,059	698	1,057	704	1,053	712	1,065	711	1,049
# Members in Self-Direction **(C)	877	854	861	906	907	904	855	890	838	886	859	898
# Members receiving other HCBS **(C)	1,358	980	1,363	991	1,393	991	1,403	975	1,397	969	1,393	968
NF Days (non-Medicare covered days) (C)												
(* non-Medicare) (**lag in data of two months)												

Legend:

ER= Emergency Room
FH=Foster Home
HCBS= Home and Community Based Services
Hosp= Hospital
NF=Nursing Facility
PCP= Primary Care Provider
CMS 1500- physicians, case management agencies, RACCP homes, home health, etc.
CMS UB04- nursing facilities, FQHC, hospitals

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* Duplicates included