FFY
2015 & 2016
(Consolidated)

Hawaii QUEST Expanded Section 1115 Annual Report

Reporting Period:
October 1, 2014 - September 30, 2016

(Demonstration Years 21 & 22)

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Introduction

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

Hawaii's QI 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, 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 for whom 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.

Healthcare 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.

Effective January 1, 2015 QUEST and QExA were combined to become QUEST Integration (QI).

The QI 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 QI program on January 1, 2015. This contract expires on December 31, 2018 with three optional one-year extensions.

Operational & Policy Developments

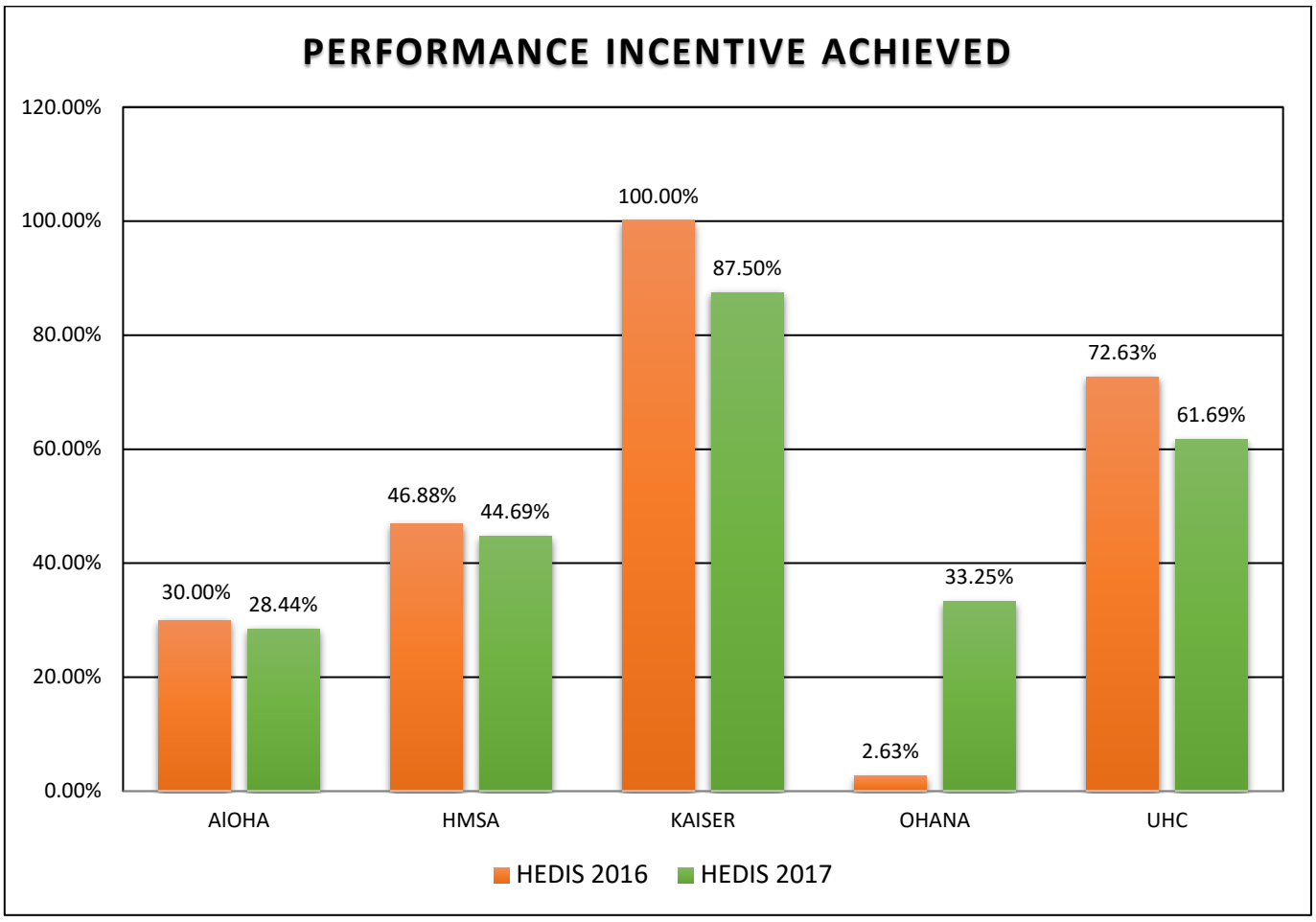
During the reporting period, MQD worked with Managed Care Organizations (MCO) on the implementation of the QI program.

The MQD uses HEDIS results to monitor progress in these areas for the QI health plans. The QI health plans had a withhold of $2.00 PMPM for the non-ABD population and $1.00 PMPM for the ABD population. These entire withhold amounts were available for both the CY 2015 and CY 2016 P4P Program. The MQD improved its Pay for Performance (P4P) in the QI program.

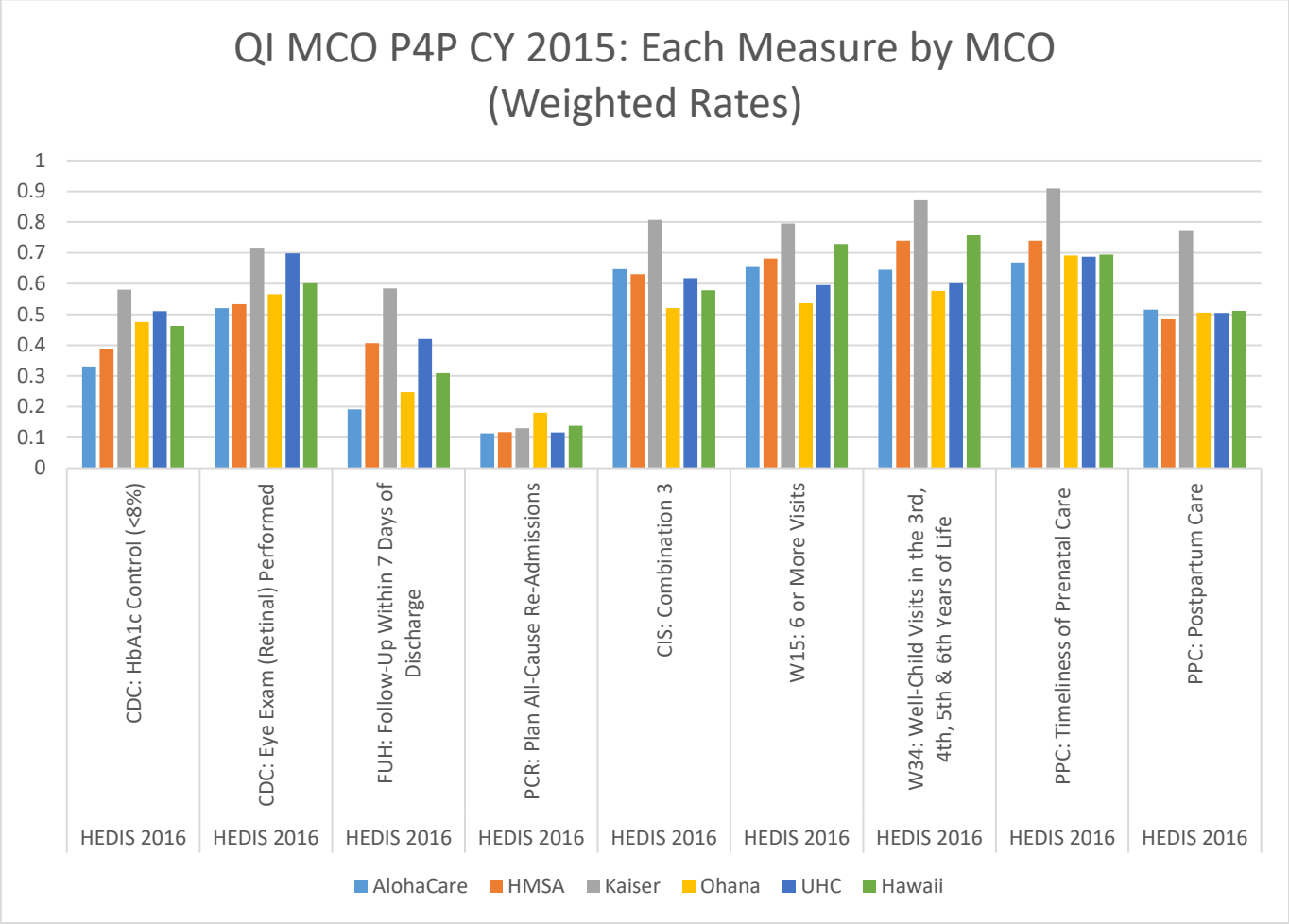
The following were improvements made to the QI P4P Program beginning CY 2015:

- Expanded measure set – increased number of measures from six (6) to nine (9)
- Recognized both improvement and goal achievement of individual measure scores – added incremental achievement targets to the current excellence target, with corresponding additional percentage incentives
- Weighted the measures differently based on the percentage of ABD enrollment each MCO served during the time period

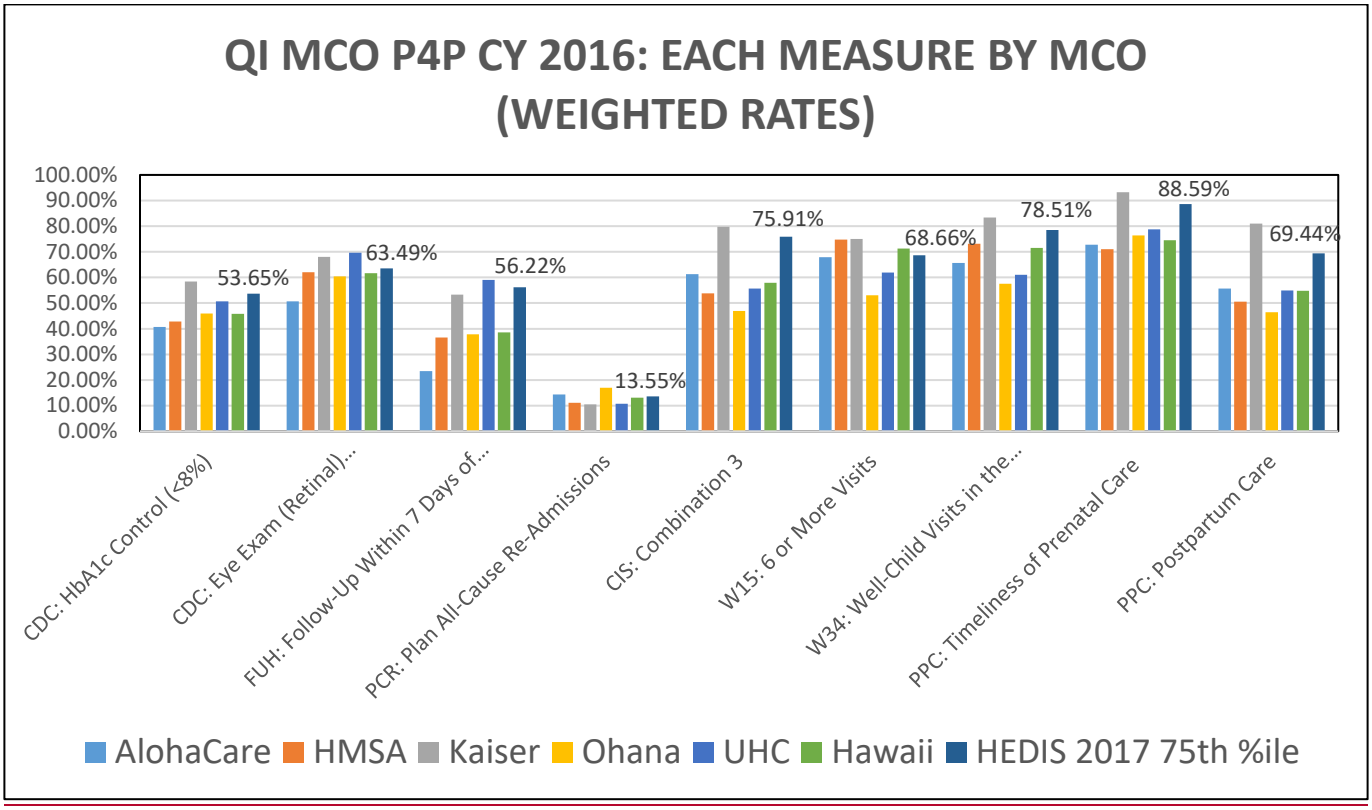
The result of these P4P changes has been broader participation achievement of intermediate goals by a broader spectrum of the QI MCOs. Whereas in past years a maximum of only two QI MCOs in any year achieved any P4P payout, in the first two years of the new P4P each and every QI MCO participated in the P4P payout. This serves to keep each QI MCO engaged in the quality improvement process no matter where they are on the performance spectrum. The following graph shows the amount of the performance incentive each of our five MCOs achieved over the CY 2015 and CY 2016 periods (these CYs correspond to HEDIS 2016 and HEDIS 2017, respectively):



Kaiser's HEDIS scores were consistently the highest among our five MCOs in CY 2015, continuing the trend of past years. HMSA and UHC both scored relatively well in the CY 2015 period as compared to their peers, and also on an absolute basis on select measures. The following graph shows the five MCO's performance for each HEDIS measure in CY 2015, along with a comparison against the Hawaii Medicaid composite:



Although Kaiser continued their dominance in the CY 2016 scoring, HMSA and UHC both exceeded the 75th %ile target for several measures in this period. Ohana also showed overall scoring improvement over the prior year's performance, and AlohaCare also represented well in a few measures. The following graph shows the five MCO's performance for each HEDIS measure in CY 2016, along with a comparison against the Hawaii Medicaid composite and the HEDIS 75th %tile score:



Outreach and Innovation 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 Kauhale (community) On-Line Eligibility Assistance System (KOLEA). DHS encouraged 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 the KOLEA system and submit applications for the State Based Marketplace through the Hawaii Health Connector portal.

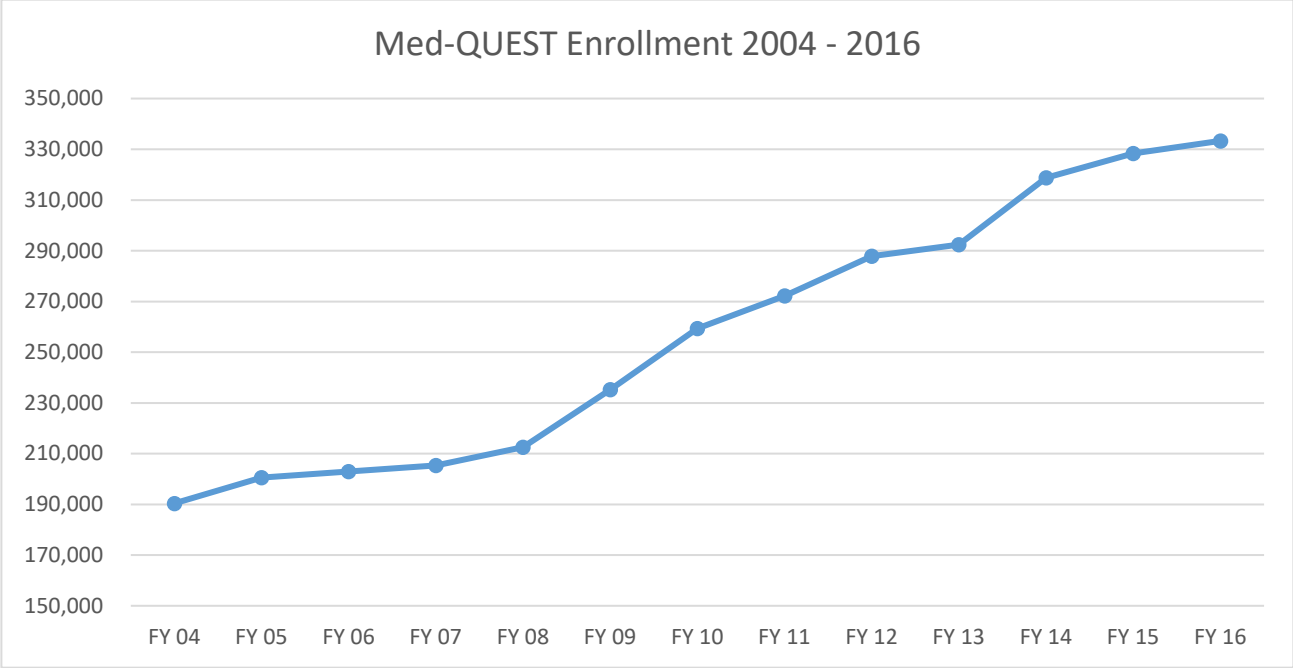
In addition to encouraging applicants to apply through the KOLEA system, DHS-Med-QUEST Division established a new branch in December, 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. The program focused its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as houselessness, lack of transportation, language/cultural barriers and justice-involved populations. Due to the multiple challenges faced by these individuals/families, they are traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that can meet the people where they congregate and offer on-the spot application assistance has been helpful in serving this high-risk population.

For those in the community who are below the 138% of the Federal Poverty Level, but who were deemed ineligible for Medicaid due to their citizenship status (Immigrants here less than 5-years and non-pregnant, non-blind, non-disabled 19-64 year olds from the Nations under the Compact of Free Association, including the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau) the HCOB team provided assistance with the completion of their Marketplace applications for health insurance. This expanded assistance is vital to meeting the expectations of the ACA that requires individuals without qualified exemptions be insured. During this reporting period, the HCOB team worked closely with MQD's Medical Director to address the growing number of applications received from uninsured individuals seeking assistance with one-time-emergent care coverage. These 500+ uninsured individuals have either been connected with Medicaid coverage, or have been placed on a high-priority outreach list in preparation for the 2017 Marketplace Open Enrollment.

Enrollment

The Demonstration had a 29% 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 State Fiscal Year 2006. See chart below for visual of the increase in enrollment of the Demonstration program in Hawaii.



Outcomes, Quality and Access to Care

MQD Quality Strategy

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015, and subsequently submitted a revised draft quality strategy on September 30, 2015. MQD received further feedback from CMS on April 5, 2016, and subsequently submitted a revised draft quality strategy on May 6, 2016. In a letter from CMS dated July 8, 2016, Hawaii received final approval of its Quality Strategy from CMS. The approved quality strategy is mostly consistent with the previously approved 2010 version.

A copy of the Quality Strategy is posted at the MQD website (https://medquest.hawaii.gov). The 2016 Hawaii MQD Quality Strategy, our current Quality Strategy, was approved by CM on July 7, 2016.

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 QI programs' reported HEDIS 2015 and 2016 measures, including the validated HEDIS 2015 and 2016 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 2015. The Adult CAHPS survey was for the QI programs and the Child CAHPS survey was for the CHIP enrollees.

In the spring of 2016, MQD performed one Adult and one Child CAHPS survey. The Adult CAHPS survey was for the QI programs and the Child CAHPS survey was for the CHIP enrollees. Members of the QI health plans that are Medicaid adults and children were provided an opportunity to participate in this survey. CHIP enrollees of QI had their own survey for reporting to CMS. The CHIP report is Statewide and not by health plan due to limited enrollment. See Attachment A for a copy of the QI 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.

QI HEDIS 2015 and 2016

For HEDIS 2015, During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS or non-HEDIS performance measures. Health plans with aged, blind, or disabled (ABD) populations were required to report on 36 measures. The health plans with non-ABD populations were required to report on 33 measures. CCS was required to report on nine HEDIS measures and two non-HEDIS measures. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Access to Care
- Utilization
- Effectiveness of Care

The measurement period was calendar year (CY) 2014 (January 1, 2014, through December 31, 2014), and the audit activities were conducted concurrently with HEDIS 2015 reporting. All five former QUEST plans (AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP) were required to report the non-ABD measures. The two former QexA health plans ('Ohana and UHC CP) were required to report the ABD measures. In addition, 'Ohana was required to report rates for the CCS-specific measures.

The most recent reported HEDIS year for QI is HEDIS 2016. The measurement period was CY 2015 (January 1, 2015, through December 31, 2015), and the audit activities were conducted concurrently with HEDIS 2016 reporting. The five QI health plans (AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI) were required to report the QI, aged, blind, or disabled (ABD), and non-ABD measures. In addition, 'Ohana CCS was required to report rates for the CCS program-specific measures.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 31 measures, yielding a total of 96 measure indicators, for the QI population. For the ABD population, health plans were required to report on 32 measures, yielding a total of 100 measure indicators. The health plans were required to report on 30 measures, yielding a total of 95 measure indicators, for the non-ABD population. 'Ohana CCS was required to report on 10 measures, yielding a total of 16 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Access to Care
- Effectiveness of Care
- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

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 Integration (QI) and the CCS 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 QI plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ʻOhana Health Plan, and UnitedHealthcare Community Plan and also the CCS Program. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning January 1st and ending December 31st of the report year, and are due to Med-QUEST on approximately June 30th 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. We do though, have developed state-specific measures. All plans and the CCS program are concurrently audited by our External Quality Review Organization (EQRO).

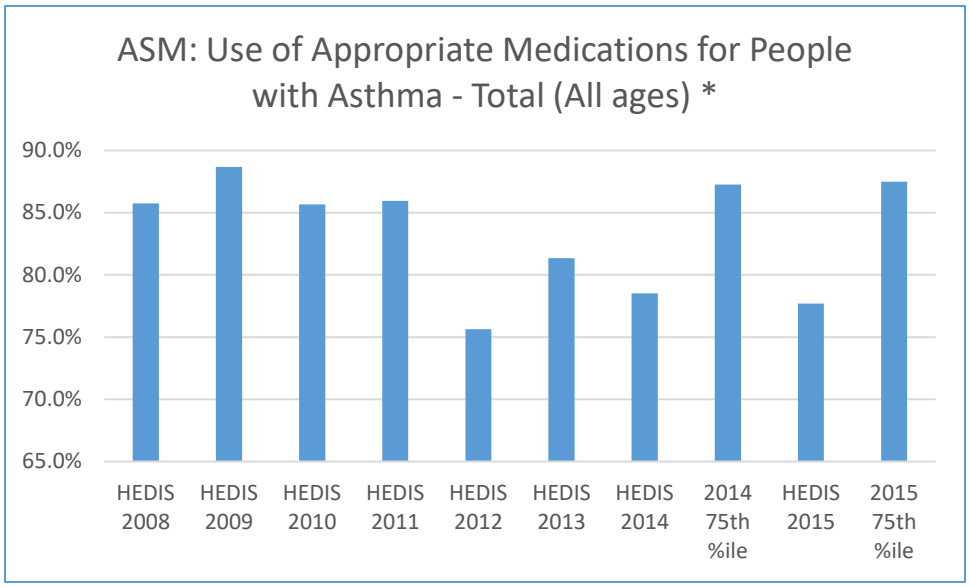
Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of HEDIS measures. The measures presented 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 QI 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 2016. A comparison is made to the 2015 and 2016 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 and Plan All-Cause Readmissions (PCR) measures, 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.

2015

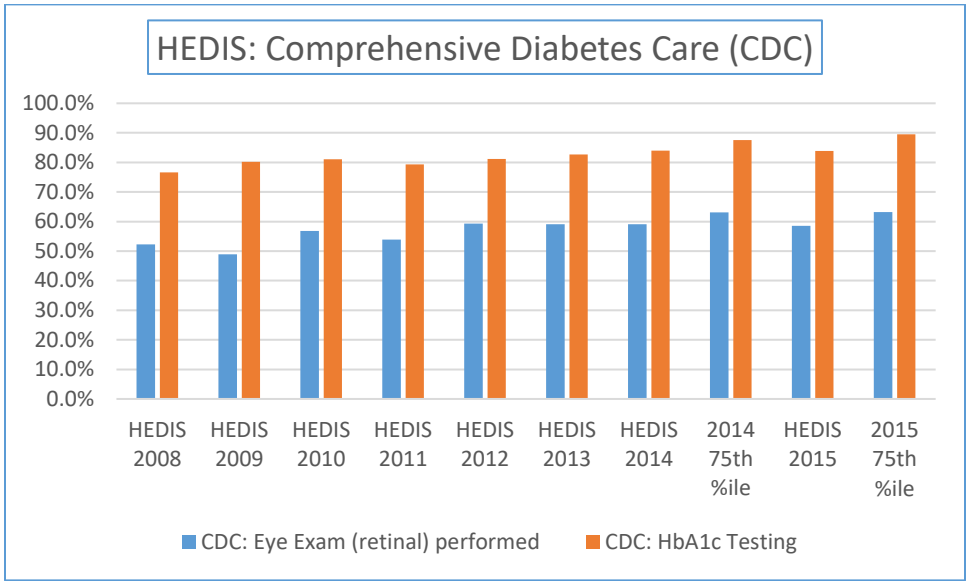


ASM:

- 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 2015, 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 progressively increased the rates in later years.

- The 2015 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 2015, the latest year with national averages, this target is slightly 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 2015, 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 four years reported. The latest year (2015) reported a decreased rate. The first two years (2008 and 2009) reported the lowest rates.

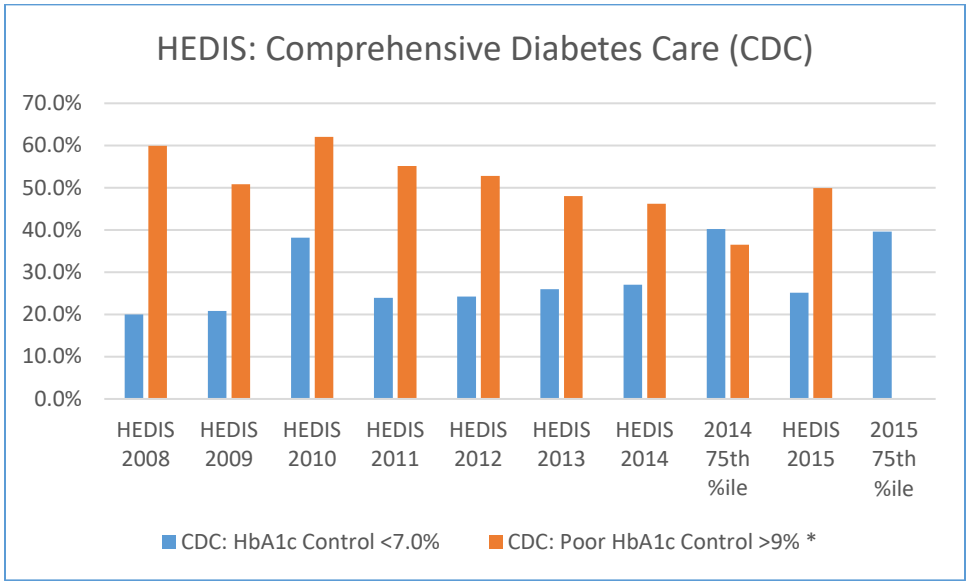
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target was not met.

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 2015, 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 past seven years reported. The latest year (2015) reported a rate consistent with the previous year 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 2015, 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 2015, 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 past seven years reported. The latest year (2015), however, reported slightly lower rate 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 seven 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 2015, the latest year with national averages, this target was consistent with 2014.

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 2015, 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 past seven years reported. For 2015, however, there was an increase in rates, the score went from 46.2% to 49.9%, 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 2015, unfortunately, the target data was not available.

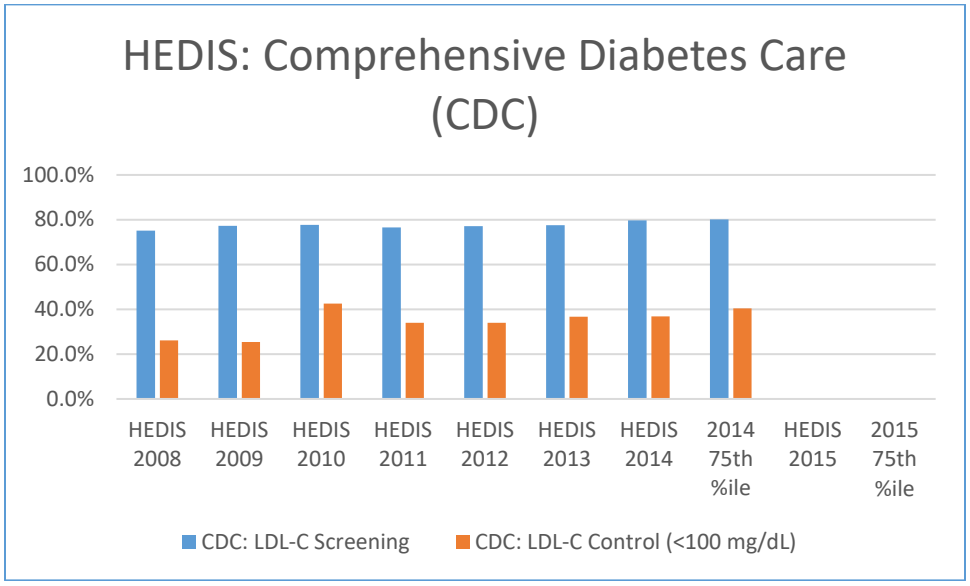


Figure 1: Note that the CDC LDL-C Screening and LDL-C < 100 measures were retired in HEDIS 2015.

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 past 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.

- The CDC LDL-C Screening measure was retired in HEDIS 2015.

CDC – LDL-C Control:

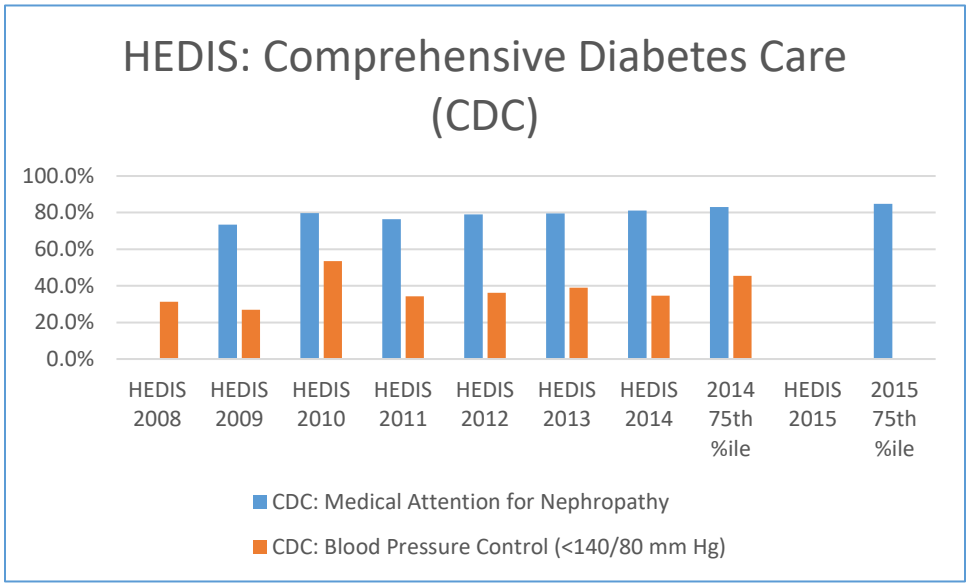
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2014, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- 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 previous 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.

- The CDC LDL-C < 100 measure was retired in HEDIS 2015.



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 past 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 2015, this target is higher than all of the years reported.

- Unfortunately, the data for the 2015 score is unavailable.

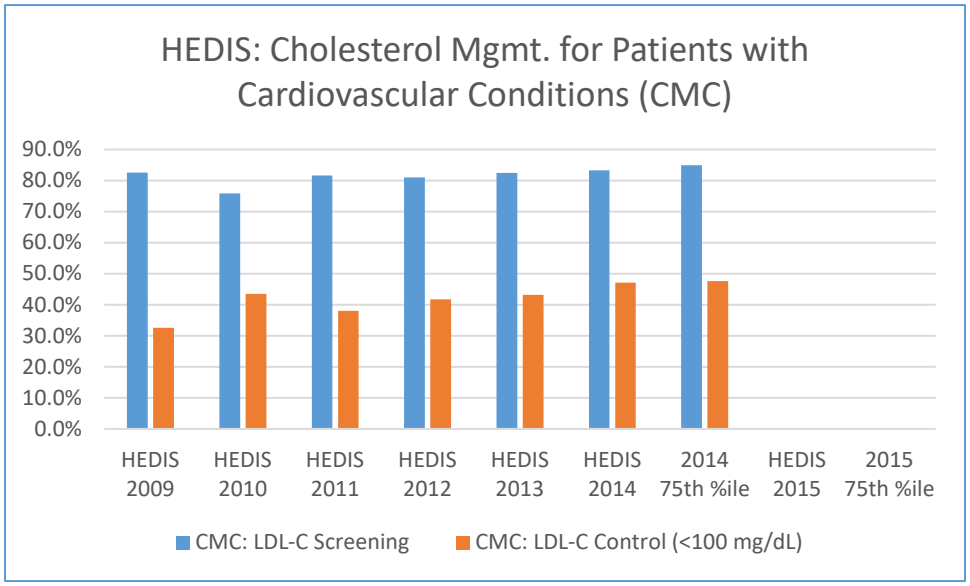
CDC – Blood Pressure Control (<140/80 mm Hg):

- 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.

- The CDC BP <140/80 measure was retired in HEDIS 2015.



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 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 2014, the latest year with national averages, this target was higher than all of the years reported.

- The CMC-LDL-C Screening measure was retired in HEDIS 2015.

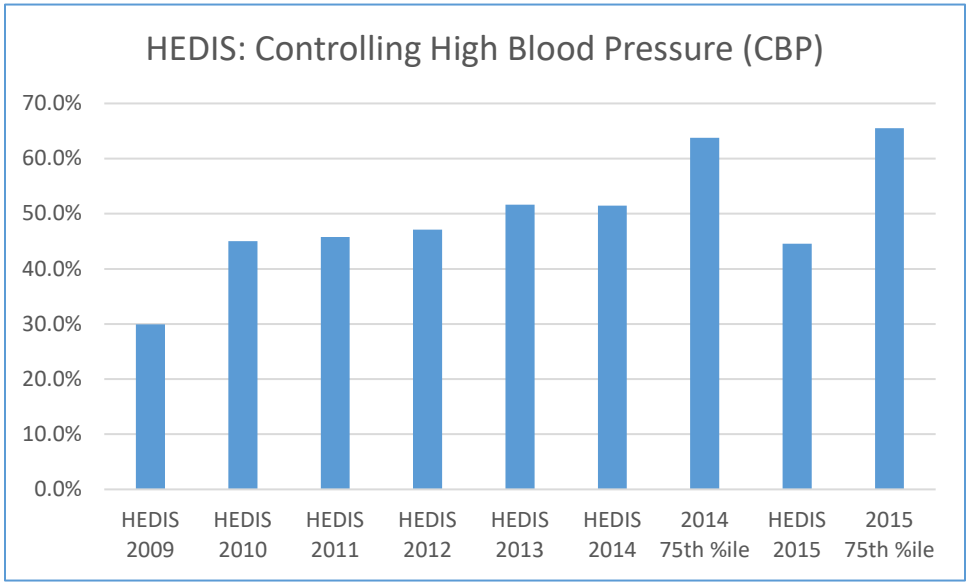
CMC – LDL-C Control:

- 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 past 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.

- The CMC-LDL-C Control (<100mg/dL) measure was retired in HEDIS 2015.

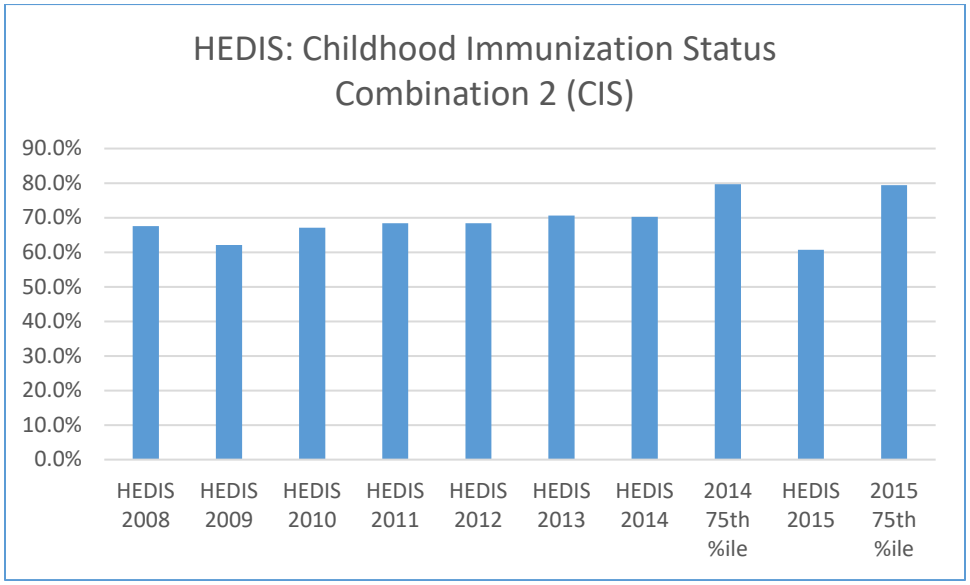


CBP:

- 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 2015, 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 was a clear up trend in the rates of the past six years reported. From 2009 thru 2013, each subsequent year's score is higher than the last. The 2014 rate (51.5%) had been consistent with the previous year's (2013) rate (51.6%). The 2015 rate (44.6%), however, was significantly lower.

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target was higher than all of the years reported.

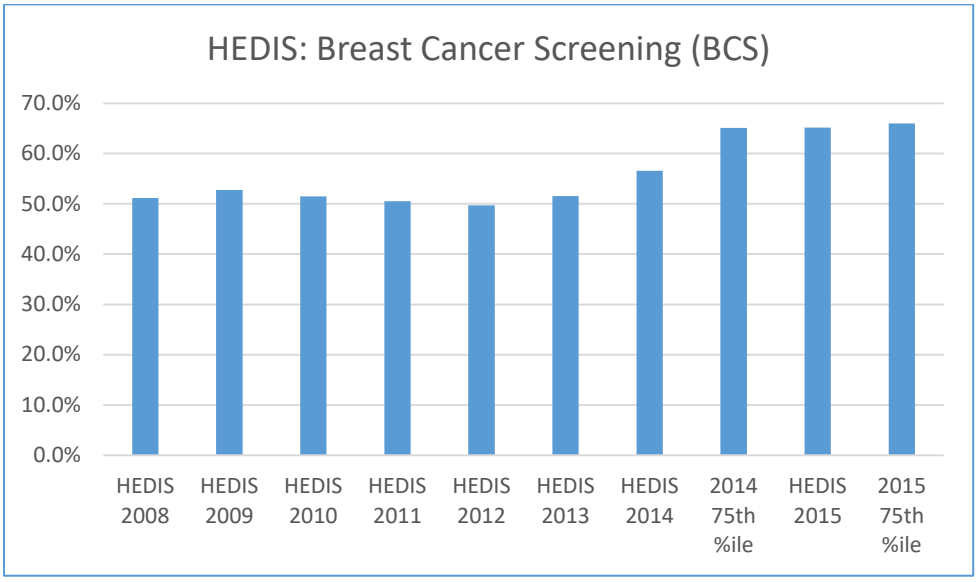


CIS:

- 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 60.7% and 71% from 2008 to 2015, with the highest rate of 70.6% occurring in 2013 and the lowest rate occurring in 2015.

- There was 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%. Then, in 2015, the rate plummeted to 60.7%.

- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target (79.4%) was slightly lower than the highest target of all, from 2014 (79.7%).

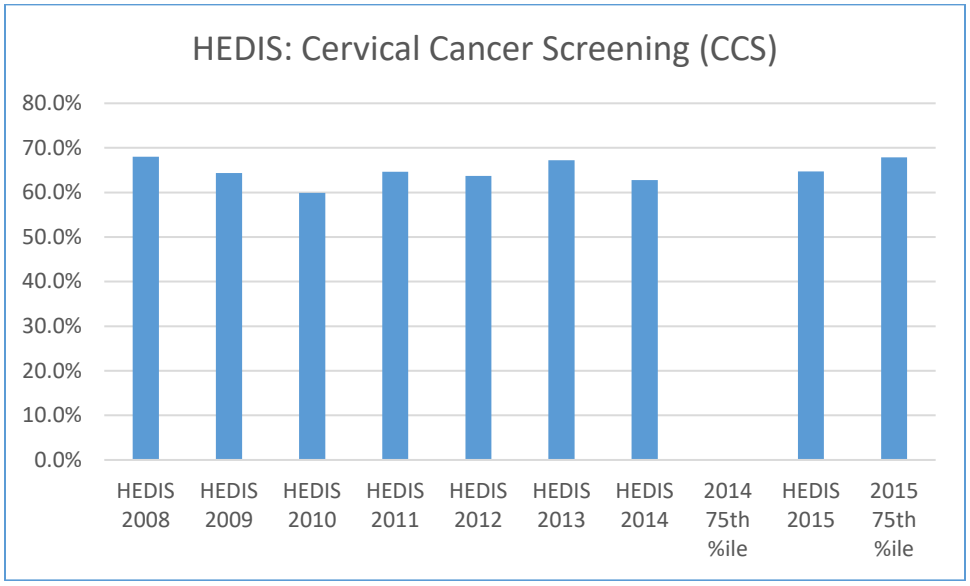


BCS:

- The statewide Medicaid percentage of women 40 – 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 65.2% from 2008 to 2015, with the highest rate of 65.2% occurring in 2015 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 three years' rates reported are trending positively (2013 with 51.5%, 2014 with 56.6% and 2015 with 65.2%), showing strong improvement.

- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target was higher than all of the years reported.

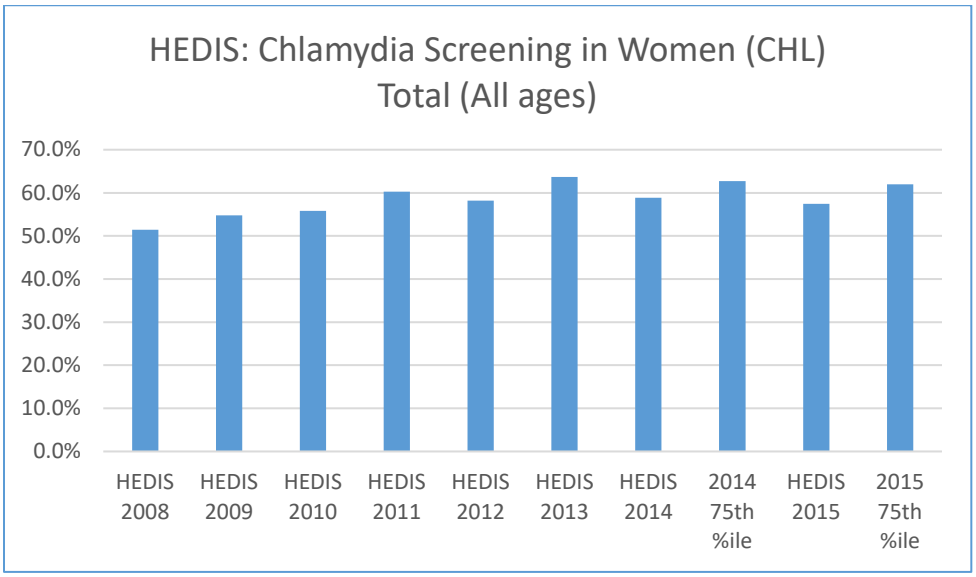


CCS:

- 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 2015, 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. But, in 2015 the rate improved to 64.7%.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target 67.9%. Unfortunately, there is no previous data available for comparison.

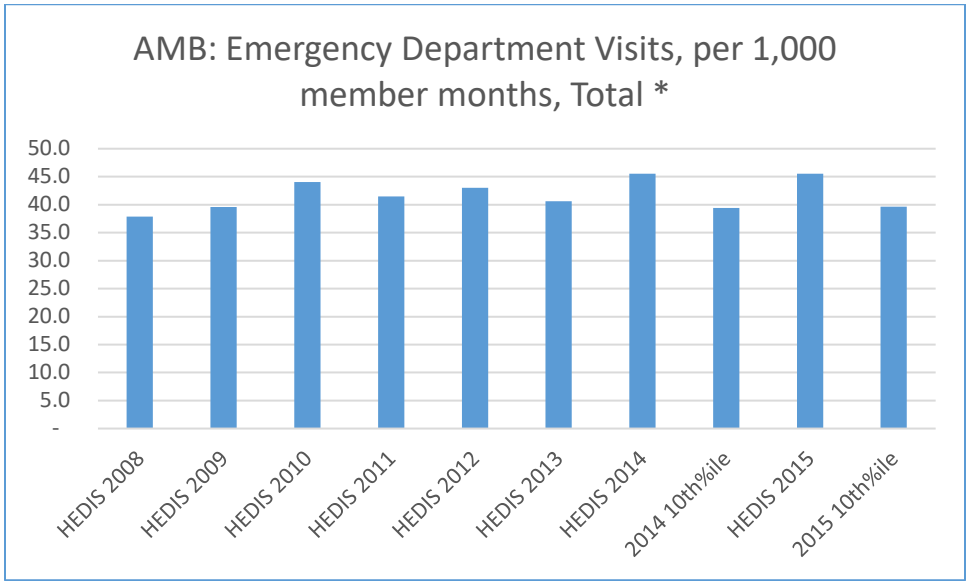


CHL:

- 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 2015, 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. The 2014 rate (58.9%) started a downward again which continued in 2015 (57.4%).

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target was not met as when HI met its quality strategy target in 2013.



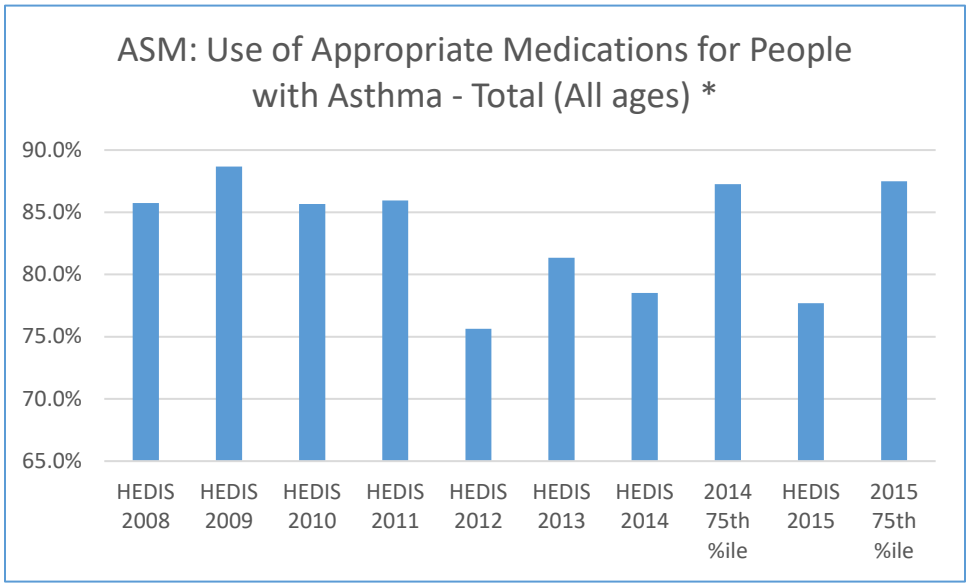
AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 38.0 and 46.0 from 2008 to 2015, 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 eight years reported. The rate in 2014 (45.6) is at an all-time high (bad) with the 2015 rate (45.5) only a 0.1 better.

- 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 six years reported; For the 2015, the latest year with national averages, the target was lower (bad). Therefore, HI did not met its quality strategy goal for ambulatory care.

2016

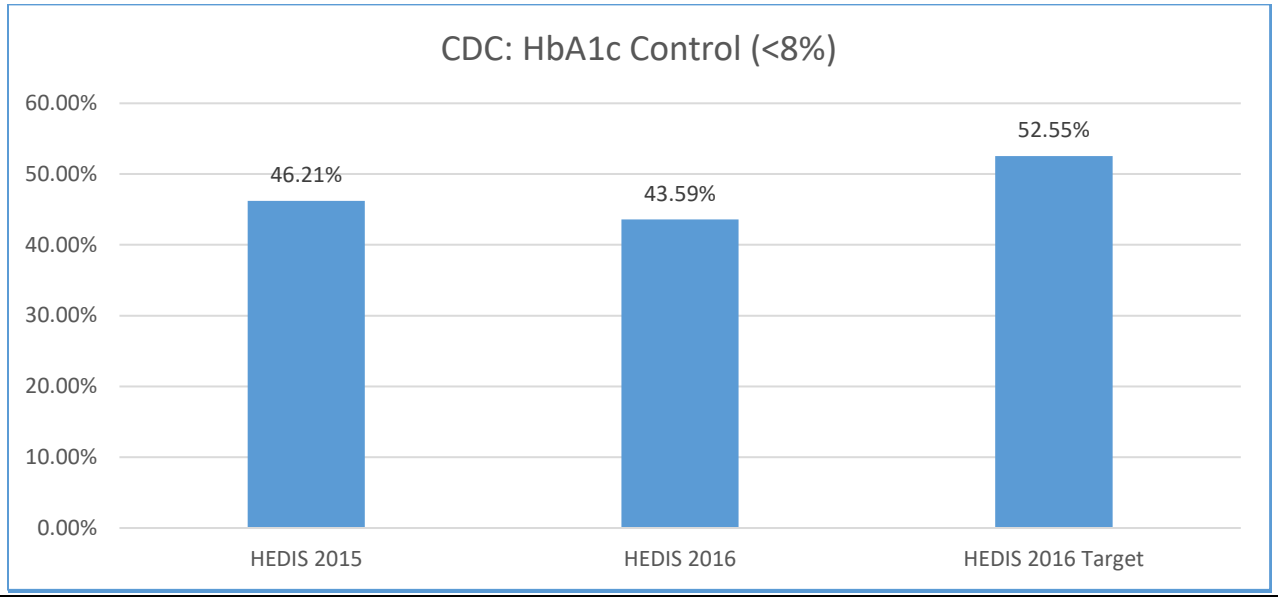


ASM:

- 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 2016, 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 progressively increased the rates in later years. The 2016 rate was slightly lower than the 2015 rate, 0.6% lower.

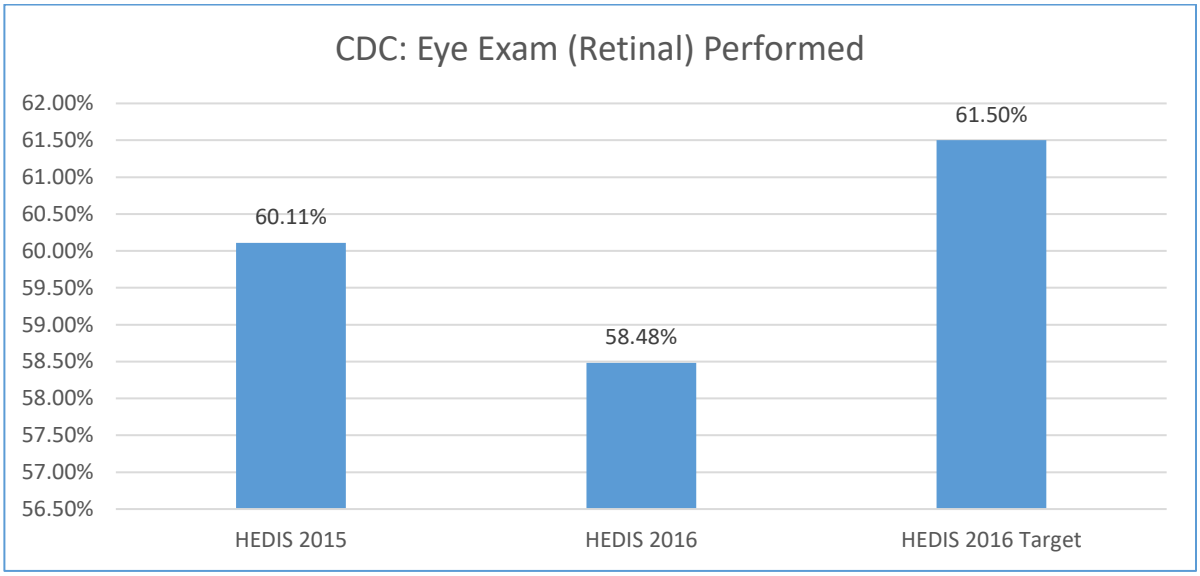
- The 2016 year's score have decreased since the marked improvement made in 2013 and is ranked second lowest overall.

- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. However, the 2016 75th percentile was not available. Also, please note, this measure has since been retired. But for the 2016 result, compared to the latest year with national averages, this target is slightly lower than the previous years reported, with the exception of 2009 when its rate (88.7%) seems to have met it.



CDC – HbA1c Poor Control < 8.0%:

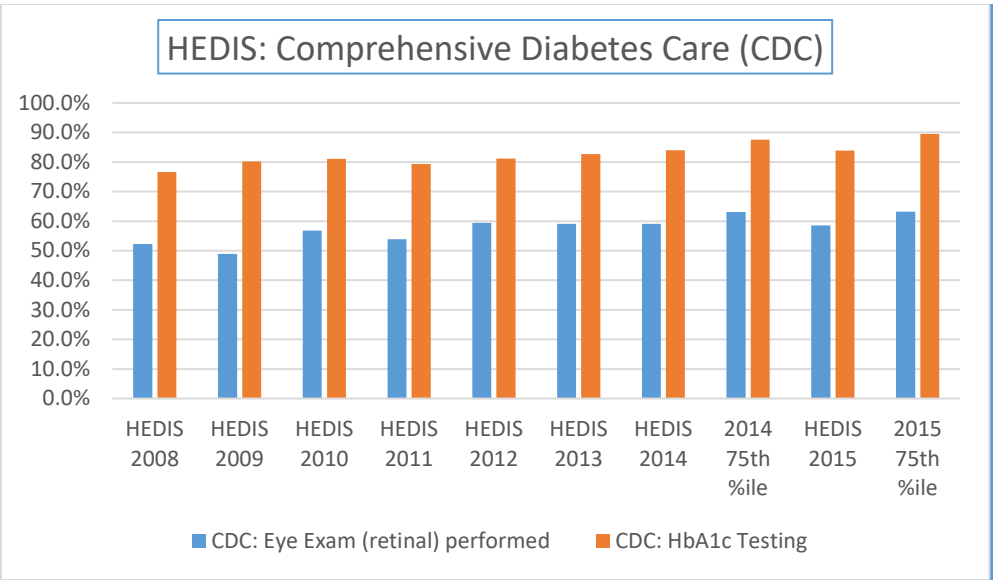
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control.
- The previous year (2015) had a higher rate than the current year (2016).
- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the CY2015, the latest year with national averages, the target was not met.



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. There is significant decrease from the previous year (2015).

- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2016, the latest year with national averages, the target was not met.



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 2015, 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 four years reported. The latest year (2015) reported a decreased rate. The first two years (2008 and 2009) reported the lowest rates.

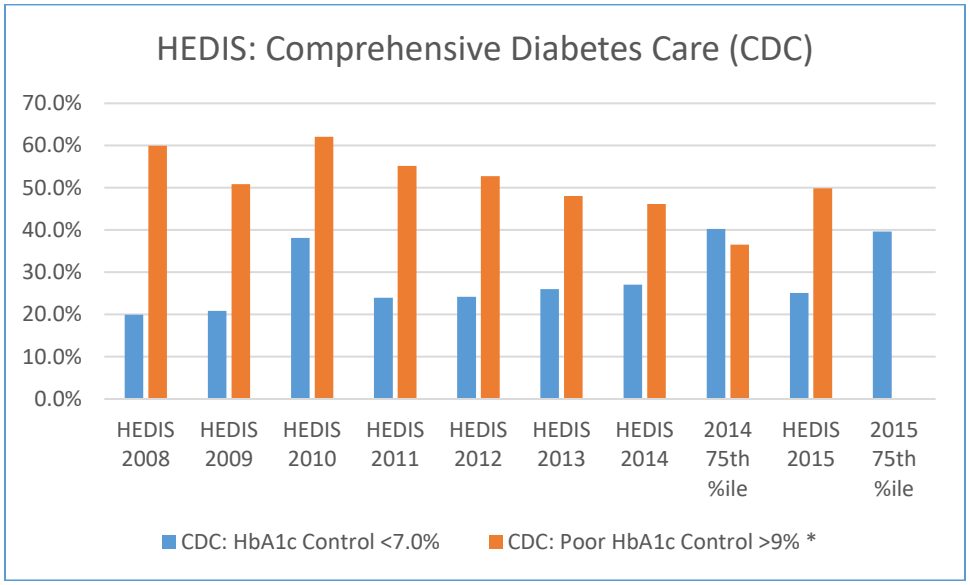
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2015, the latest year with national averages, the target was not met.

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 2015, 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 past seven years reported. The latest year (2015) reported a rate consistent with the previous year 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 2015, the latest year with national averages, this target was above all of the years reported.

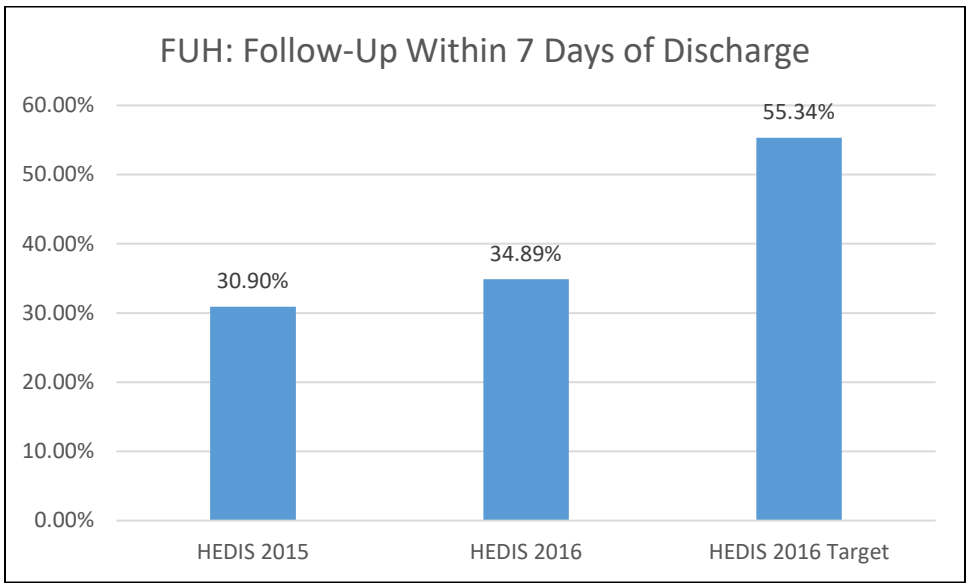


CDC – HbA1c Poor Control > 9.0%:

- 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 2015, 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.

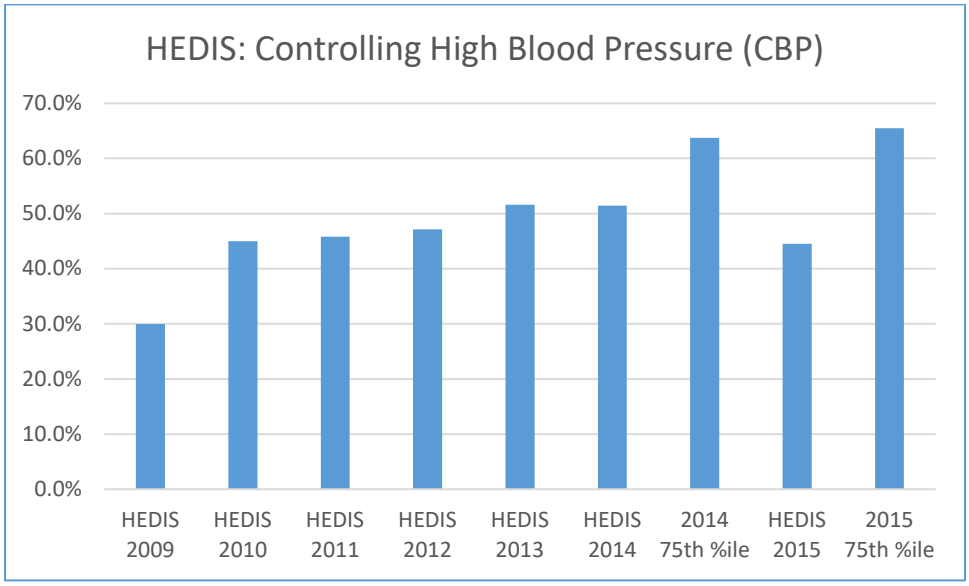
- There is a slight downtrend (good) to flat trend in the rates of the past seven years reported. For 2015, however, there was an increase in rates, the score went from 46.2% to 49.9%, with the lowest score occurring in 2014 (46.2%).

- 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 2015, unfortunately, the target data was not available.



FUH (Follow-Up Within 7 Days of Discharge):

- The statewide Medicaid percentage of members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner increased from 30.90% to 37.89% in one year.
- The HI Quality Strategy target percentage for the FUH: Follow-Up Within 7 Days of Discharge measure is the 75th percentile of the national Medicaid population.



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 2015, 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.

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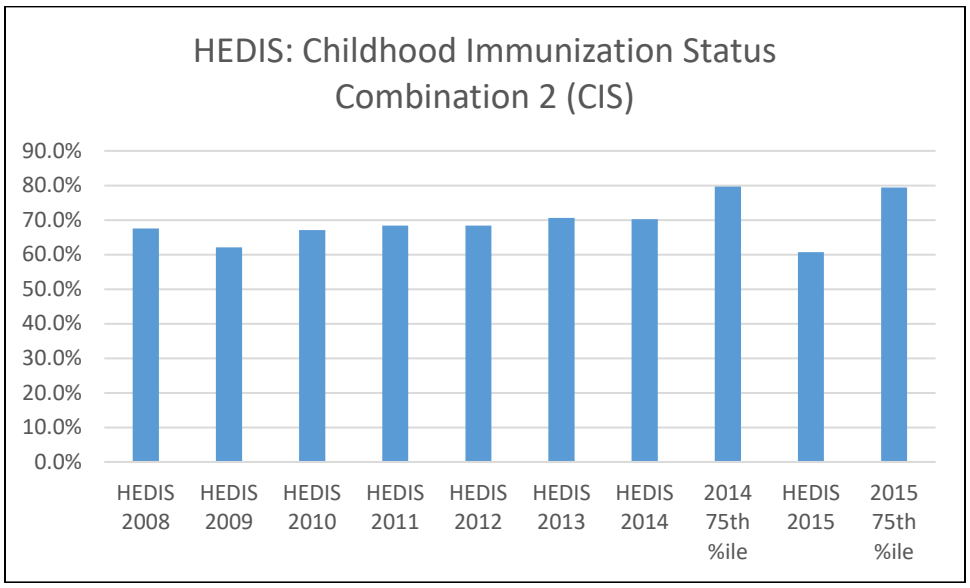

CIS:

- 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 60.7% and 71% from 2008 to 2015, with the highest rate of 70.6% occurring in 2013 and the lowest rate occurring in 2015.

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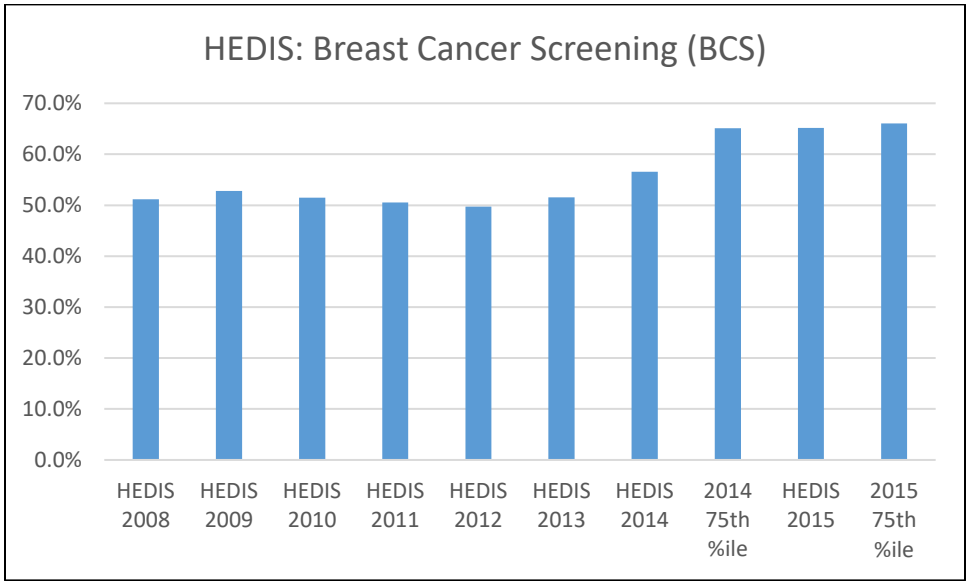

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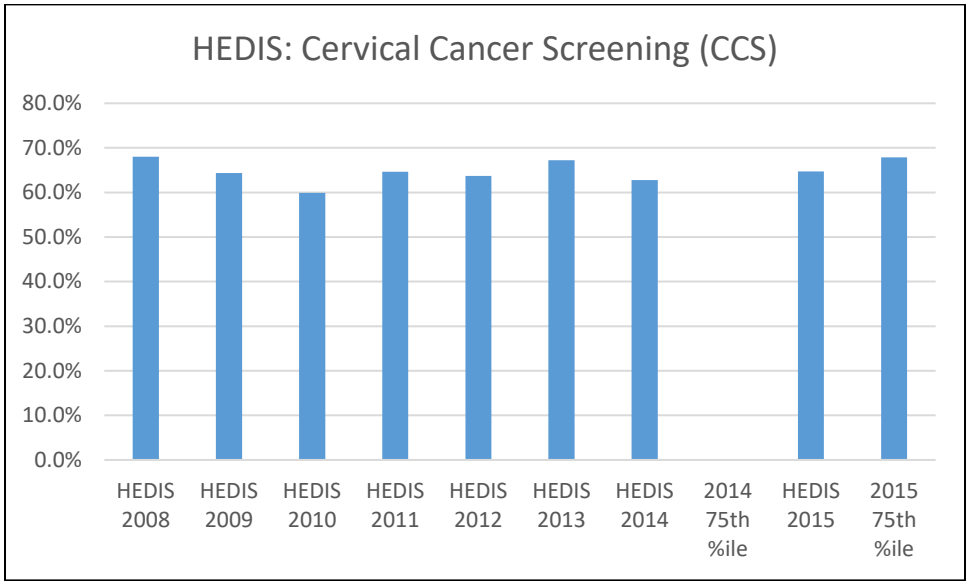

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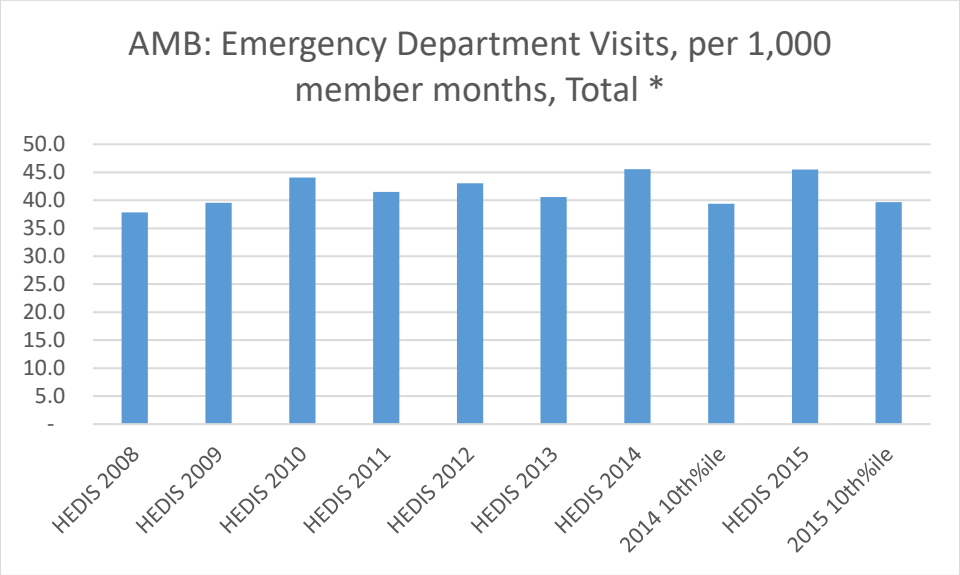

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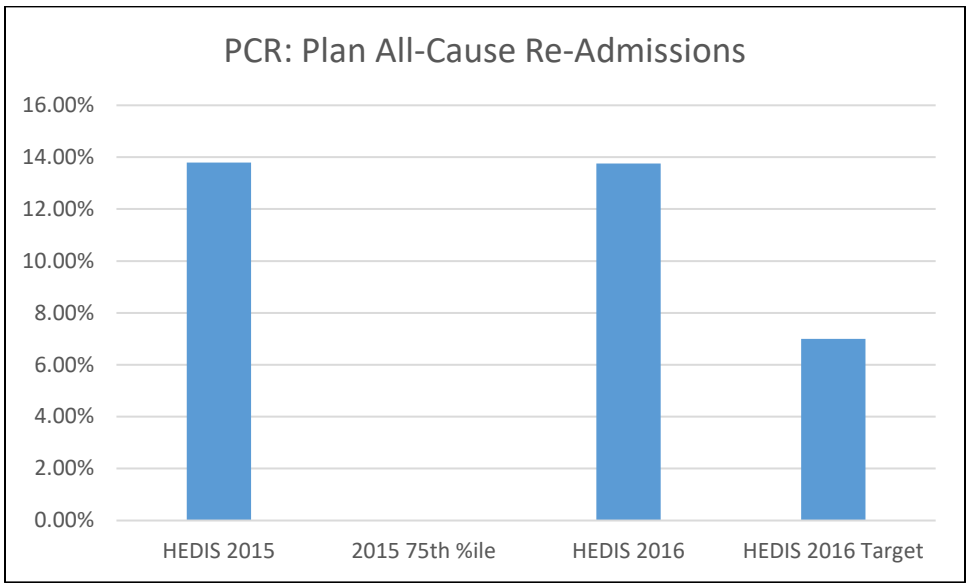


PCR:

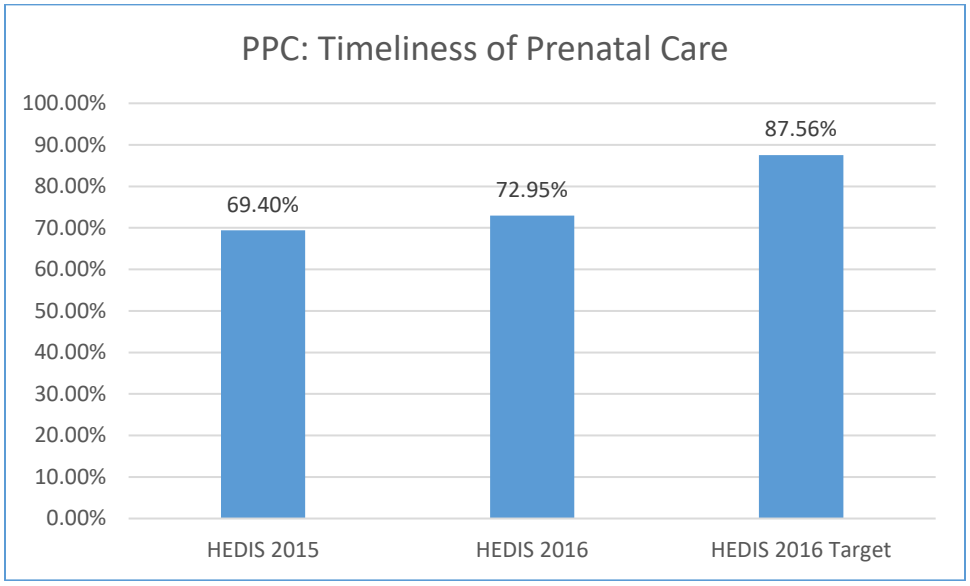
- For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (I) (denominator).
2. Count of 30-Day Readmissions (numerator).
3. Average Adjusted Probability of Readmission.

- The statewide Medicaid rate of Plan All-Cause Re-Admissions decreased slightly from 13.8% in 2015 to 13.76% in 2016. Note that since this is an inverse measure, where the higher the numeric rate is the worse the score is, this is an improvement.

- However, because of the limited data, we cannot determine a trend at this time.

- For the Plan All-Cause Readmissions: Observed-to-Expected Ratio – 18-64 National HMO Average rate, the 75th National Percentile for 2015 was not available however, the 2016 target is 7%, which neither year accomplished.



PPC:

- The statewide Medicaid percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal care. *Timeliness of Prenatal Care* is the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. There was in increase in rate from 2015 to 2016.

- However, neither year reached the 2016 target of 87.56%.

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.

Copies of the 2015 and 2016 EPSDT Reports (2015 and 2016 Hawaii CMS 416 Reports) are posted at the MQD website (https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt.html).

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 CAHPS 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.

In the 2015, the overall response rate was 19.6% which exceeded the 2013 response rate (5.8% points higher). In 2014, it was 39.9% (35.2% for QUEST and 52.1% for QexA) overall. The 2016 QI Program aggregate’s response rate was 31.6%, approximately 4.4 percentage points above the national adult Medicaid response rate reported by NCQA for 2015, which was 27.2%.

The “question summary rates” are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010, 2012, 2014 and 2016. The Child Medicaid survey was done in 2009, 2011, 2013. And 2015. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan. 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.

Copies of the 2015 and 2016 EQRO Technical Reports (2015 and 2016 External Quality Review Report of Results for QI Health Plans and the CCS Program) are posted at the MQD website (https://medquest.hawaii.gov/en/resources/consumer-guides.html).

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 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

Please see Attachments B and C for 2015 and 2016 health plan initiatives.

CMS-416 EPSDT Measures Initiatives

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.

CAHPS (QUEST) Initiatives

Please see Attachments B and C for 2015 and 2016 health plan initiatives.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QexA and continued into the QI.
    - 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.

- Standardized assessment tools for HCBS

    - At the start of the QI Program, MQD and the health plans began the process of developing an updated Health and Functional Assessment (HFA) tool. There are currently multiple HFA tools for various Medicaid populations, and this effort will streamline the HFAs into a single tool for all populations.

    - 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.

- Effective October 1, 2013, MQD enacted eligibility for beneficiaries, ten-days prior to submittal of application.

- 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, that affect our QI health plans, the Developmental Disability and Intellectual Disability (DD/ID) program, and the Going Home Plus (GHP) program. MQD implemented the CMS Quality Framework for Home and Community Based Services (HCBS) in SFY 2012. 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 long-term care will need to be developed in the future in partnership with our stakeholders.

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.

During demonstration years 21 and 22, MQD collaborated with QI health plans to improve the Pay-for-Performance (P4P) Incentive Program. Some of the improvements included: rewarding quality score improvements in addition to achieving benchmark targets; broadening the scope of quality measures that were included in the P4P program; considering quality measures that the QI health plans include in other lines of business (i.e., commercial and Medicare quality measures), and paying P4P incentives to each of the five QI health plans in calendar year 2015.

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 2015, MQD moved into the third 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 the 2015 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the CCS program, using monitoring tools to assess and document compliance with a set of federal and State requirements. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards were reviewed within a three-year period for all health plans. The standards selected for review were related to the CCS program's State contract requirements and the federal Medicaid managed care regulations in the Code of

Federal Regulations (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions and record reviews were conducted.

The second compliance review activity in 2015 involved HSAG's and the MQD's follow-up monitoring of the three health plans that were required to take corrective actions related to findings from HSAG's 2014 compliance review, and the follow-up monitoring of CCS' corrective actions related to its 2015 compliance review.

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 CCS. HSAG evaluated the degree to which CCS 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, Subpart D. The five standards included requirements that addressed the following areas:

- Member Rights and Protections and Member Information
- Member Grievance Systems
- Access and Availability
- Coverage and Authorization
- Coordination and Continuity of Care

CCS 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. For CCS, the areas for oppurtunities of improvement were Member Grievance System and Coverage and Authorization. By July 2015, 'Ohana CCS completed all of the CAP activities as planned and was found to be in full compliance with the standards.

In Calendar Year (CY) 2016, a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program. The two activities conducted were a review of select standards for the QI and CCS programs and follow-up monitoring of CCS'corrective actions related to its 2015 compliance review.

The following are the five standard areas reviewed:

- Member Rights and Protections and Member Information
- Member Grievance Systems
- Access and Availability
- Coverage and Authorization
- Coordination and Continuity of Care

Overall, the health plans performed strong (97-99% out of 100% possible score) with all the standards except the Member Rights and Protections and Member Information standard. However, even with this last standard, the plans in the upper brackets at 93%.

Performance Improvement Projects (PIP):

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2015, HSAG validated two PIPs for each of the QUEST Integration and CCS health plans, for a total of 12 PIPs. The five QUEST

Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.

In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-9] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

By 2016, all of the health plans progressed to testing intervention for the rapid-cycle PIPs. Module 5 (PIP conclusions), the last phase, was due at the end of the year and achievements will be evaluated in the early part of 2017.

Annual External Quality Review Report of Results For the QI Health Plans and the CCS Program:

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.

MQD is continuing to actively work 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.

Improvement of Health Plan Report Forms and Monitoring Tools

In demonstration years 21 and 22, MQD continues to align the report forms and monitoring tools for these programs wherever possible. MQD has developed 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 23. 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.

[1 -9] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: September 24, 2015.

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 years 21 and 22 (January 1 to December 31, 2014 and January 1 to December 31, 2015).

Financial/ Budget Neutrality Development/ Issues

The MQD submitted budget neutrality for each quarter in demonstration years 21 and 22.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	October to December 2014 (1st qtr totals)	January to March 2015 (2nd qtr totals)	April to June 2015 (3rd qtr totals)	July to September 2015 (4th qtr totals)
Children (EG1)	336,744	343,377	353,875	366,819
Adults (EG2)	141,500	133,643	128,390	122,520
Aged (EG3)	76,152	83,051	71,760	73,771
Blind/Disabled (EG4)	82,523	76,175	73,213	74,157
EG 5-VIII-Like Adults	-37	-5	-32	-12
EG 6-VIII Group Combined	242,295	264,490	294,418	314,486

Without Waiver Eligibility Group	October to December 2015 (1st qtr totals)	January to March 2016 (2nd qtr totals)	April to June 2016 (3rd qtr totals)	July to September 2016 (4th qtr totals)
Children (EG1)	372,325	376,898	374,542	375,192
Adults (EG2)	115,162	114,685	114,262	120,282
Aged (EG3)	74,000	74,906	77,118	78,245
Blind/Disabled (EG4)	75,417	77,744	77,430	78,301
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	328,862	345,504	348,076	346,391

B. For Informational Purposes Only

With Waiver Eligibility Group	October to December 2014 (1st qtr totals)	January to March 2015 (2nd qtr totals)	April to June 2015 (3rd qtr totals)	July to September 2015 (4th qtr totals)
State Plan Children	335,796	342,314	352,718	365,580
State Plan Adults	141,492	133,640	128,406	122,520
Aged	76,152	83,051	71,760	73,771
Blind or Disabled	82,523	76,175	73,213	74,157
Expansion State Adults	139,433	162,686	190,223	210,905
Newly Eligible Adults	102,862	101,804	104,195	103,581
Optional State Plan Children				
Foster Care Children, 19-20 years old	948	1,063	1,157	1,239
Medically Needy Adults				
Demonstration Eligible Adults	8	3	-16	0
Demonstration Eligible Children				
VIII-Like Group	-37	-5	-32	-12

With Waiver Eligibility Group	October to December 2015 (1st qtr totals)	January to March 2016 (2nd qtr totals)	April to June 2016 (3rd qtr totals)	July to September 2016 (4th qtr totals)
State Plan Children	371,036	375,598	373,252	373,974
State Plan Adults	115,162	114,685	114,262	120,282
Aged	74,000	74,906	77,118	78,245
Blind or Disabled	75,417	77,744	77,430	78,301
Expansion State Adults	226,802	246,178	286,438	283,592
Newly Eligible Adults	102,060	99,326	61,638	62,799
Optional State Plan Children				
Foster Care Children, 19-20 years old	1,289	1,300	1,290	1,218
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children				
VIII-Like Group	0	0	0	0

Audits and Lawsuits

Audits

The MQD undergoes a single-state audit annually by KMH LLP. The PERM audit was completed by CMS for period of October 2014 to September 2015. The MQD provides CMS with a copy of the audit findings annually.

Lawsuits

Case 1:
In 2013, Medicaid pharmacy provider appealed agency decision that it was overpaid. The request for hearing was denied because the provider's request was untimely. Provider appealed the denial of the hearing request. The lower court affirmed the agency's denial, and provider appealed to the State's Intermediate Court. While the appeal was initiated in 2013, the lower court's decision was only affirmed by the State Intermediate Court of Appeals on Sept 8, 2016, in favor of the DHS.

Case 2:
In 2014, a class action suit was filed in the U.S.D.C., District of Hawaii. Plaintiffs are seeking a declaration that certain specific services for children suffering from Autism Spectrum Disorder are medically necessary and must be covered under the early periodic screening, diagnostic and treatment (EPSDT) mandate of the state Medicaid program. The State modified its new Medicaid program effective January 1, 2015, by issuing contract modifications to the five Medicaid health plans that would be providing services to Medicaid beneficiaries, including the Plaintiff class. The contract modifications do not specify that the specific services that are the subject of this lawsuit must be provided under the EPSDT mandate; it clarifies that those services are not excluded under another type of services provided under the Medicaid program, (i.e. the services are covered if they are determined to be medically necessary). The notice of modification was provided to the plans prior to the plaintiffs initiating their suit. While the case was initiated in 2014, it was still pending as of Sept 30, 2016.

Case 3:
In June 2016, Plaintiffs (elderly spouses) filed a civil rights lawsuit in the U.S.D.C., District of Hawaii, seeking declaratory and injunctive relief to allow them to live in the same care home. The couple are private pay patients who do not receive Medicaid benefits. Plaintiffs challenge the existing state authority that require community care foster family homes (CCFFH) to have a certain number of beds available for Medicaid patients. The CCFFH in which husband resides has three beds, but two are reserved for Medicaid patients. Plaintiffs allege that the law violates their fundamental right to family integrity under the due process clause of the 14th Amendment. The case was still pending as of Sept 30, 2016.

Case 4:
In Aug 2016, Medicaid provider filed appeal in State Circuit Court, challenging DHS' determination that provider was ineligible for enhanced primary care physician payments mandated under the Affordable Care Act. The agency determined that provider did not meet the qualifying requirements and requested reimbursement for overpayment. The lower court affirmed the agency determination and provider appealed to the state Intermediate Court. The decision on appeal is still pending.

Case 5:
In Sept 2014, agency conducted preliminary investigation after receiving report of alleged fraud by health plan against provider. Provider had been overbilling for drug test kits for over 1.5 years and received overpayment from several health plans. Based on federal authority, DHS suspended all Medicaid payments to provider based on its determination that there was "a credible allegation of fraud" because it preliminarily verified the health plan's allegations of fraud, and referred the matter to the Medicaid Fraud Control Unit. Provider contested the suspension of payments indicating it was a mistake in billing and use of the codes, and there was no intent to commit fraud. Administrative agency hearing decision found in favor of provider because there was not enough evidence to prove "actual fraud". Because DHS felt that the Hearing Officer did not use the correct standard for determining whether DHS was authorized to suspend payments, the DHS appealed to the State Circuit Court, but the agency's decision for provider was affirmed in Sept 2015.

Demonstration Programmatic Information Specific to

QUEST Expanded Demonstration

QUEST Integration and Fee-For-Service (FFS) Concerns

HCSB Member Grievance

During FFYs 2015 and 2016, the HCSB continued to handle incoming calls. The clerical staff take the basic contact information and assign each call to one of the social workers. MQD tracks all of the calls and resolutions. If the client call is an enrollment issue (i.e., request to change health plan), then the HCSB staff will refer such telephone call to the Customer Service Branch (CSB) which will work with the client to resolve the issue(s).

During the FFYs 2015 and 2016, the HCSB staff, as well as other MQD staff, processed approximately 296 member grievance calls.

Member Grievance Phone Calls Received by HCSB

Period		Member
FFY 15	10/1/14 – 9/30/15	189
FFY 16	10/1/15 – 9/30/16	107

FFS Consumer Issues

MQD customer call center staff handles health plan enrollment, address change, new born add-ons, plan-to-plan changes, annual plan changes, and any plan enrollment related calls.

Provider Interaction

The MQD and the QI health plans continue to meet as issues occur and also maintain the monthly health plan meeting. The meetings with these agencies are focused around continually improving and modifying processes within the health plans related to HCBS.

MQD also meets with the Community Care Foster Home providers to discuss the new home and community based rules. The public forums were held on January 14, 2015 and on January 14, 2016.

Most of the communication with providers occurs via telephone and e-mail at this time. The MQD will arrange any meetings with QI 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 66 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 8 of the 25 appeals (32%). The hearing officer felt that the actions taken by the health plan were appropriate (i.e., the appeal was upheld) in 17 of the 25 appeals (68%). In addition, 41 of the 66 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.

Appeal Category	#
Submitted	66
DHS resolved with health plan in member's favor prior to going to hearing	41
Hearings	
Resolution in DHS favor	17
Resolution in Member's favor	8

Types of Appeals	#
Medical	16
LTSS	13
Medications	12
ABA Services	4
Reimbursements	10
Others: Home Mod, DME, OT/PT	11

Enrollment of Individuals

The DHS enrolled approximately 58,295 members from October 1, 2014 to September 30, 2016. Of this group, 1007 chose their health plan when they became eligible, 16,712 changed their health plan after being auto-assigned.

In addition, DHS had 772 plan-to-plan changes from October 1, 2014 to September 30, 2016. 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, 78 individuals in the QUEST Integration program changed their health plan during days 61 to 90 after a confirmation notice was issued.

	#
Individuals who chose a health plan when they became eligible	1007
Individuals who changed their health plan after being auto-assigned	16,712
Individuals who changed their health plan outside of allowable choice period (i.e.,	772

plan to plan change)	
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	78

Behavioral Health Programs Administered by the DOH and DHS

MQD has approximately 5,000 individuals in the 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 Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). The information provided in the tables below identify the approximate number of Medicaid beneficiaries that each program continued to provide services to during the FFY 2015 and during the FFY 2016.

Program	As of September 30, 2016
Adult Mental Health Division (AMHD/DOH)	184
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,136
Community Care Services (CCS/DHS)	5,179

Reporting

The MQD receives reports consistent with the reporting requirement in the QI RFP. MQD staff review quarterly and annual reports for compliance with the QI program.

The MQD receives a monthly Dashboard report for the QI program. 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.

Dashboard compilations constituting the FFY 2015 and the FFY 2016 are provided with this report as Attachments D through F.

Annual Plan Change

During QI Annual Plan Change (APC) in October 2015, 6,921 individuals chose a new health plan that went into effect on January 1, 2016. During QI Annual Plan Change in October 2016, 6,650 individuals chose a new health plan that went into effect on January 1, 2017.

Annual Plan Change for QUEST October 2015	
	# of health plan changes (loss to plan)
AlohaCare	2,216
HMSA	1,014
Kaiser	233
‘Ohana	1,920
United	1,538
Total	6,921

Annual Plan Change for QUEST October 2016	
	# of health plan changes (loss to plan)
AlohaCare	906
HMSA	4,679
Kaiser	0
‘Ohana	242
United	823
Total	6,650

Home and Community Based Services (HCBS) Waiting List

The QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

MQD monitors the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) are required. During the FFY15, the monthly average of beneficiaries requiring LTSS was approximately 6,998. During the FFY16, it was approximately 6,189. Since the start of the program, the monthly average of beneficiaries receiving LTSS increased by approximately 41.4% for FFY15, and 25.0% for FFY16. The HCBS absorbed those increases, versus the nursing facility services. Since the program inception, the nursing facility services decreased by approximately 15.7% for FFY15, and 32.1% for FFY16.

The number of beneficiaries receiving HCBS has decreased from FFY15 to FFY16. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving LTSS. This number increased to 65.8% for FFY15, and 68.8% for FFY16.

	2/1/09	FFY15, mo av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in FFY15
HCBS	2,110	4,605	118.2%↑	42.6%	65.8%
NF	2,840	2,393	15.7%↓	57.4%	34.2%

Total	4,950	6,998	41.4%↑	

	2/1/09	FFY16, mo av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in FFY16
HCBS	2,110	4,261	101.9%↑	42.6%	68.8%
NF	2,840	1,928	32.1%↓	57.4%	31.2%
Total	4,950	6,189	25.0%↑		

Status of the Demonstration Evaluation

MQD submitted its QI Draft Evaluation Design to CMS on December 18, 2014. CMS responded with comments on September 9, 2015. The MQD has reviewed the CMS comments and had concerns about a few items. During a Quarterly 1115 Waiver Monitoring Call on October 21, 2015 the MQD shared that there were a few concerns and requested an extension on the existing deadline of November 9, 2015. CMS agreed on an extended deadline, and that a new deadline will be determined after a pending conference call to discuss these concerns. The list of concerns was sent to CMS on November 12, 2015. After a Demonstration Evaluation follow-up call that occurred on April 20, 2016, the MQD submitted on April 22, 2016 the quality measures/quality monitoring/quality projects related to the HCBS/LTSS populations that have occurred recently. As of the 4th quarter in FFY 2016, the MQD is still awaiting feedback from CMS.

Tables

Table 1A - Enrollment Counts from January 2015 to September 2016

QUEST Integration			
	January 2015	**September 2016**	**Percent Change**
Children	108,418	119,478	10.2%
CHIP	25,644	23,689	-7.6%
Current & Former Foster Care	5,885	6,009	2.1%
Pregnant Women	41,147	40,486	-1.6%
Low Income Adults	86,097	114,792	33.3%
Medical Assistance ABD	47,795	49,203	2.9%
State Funded ABD	0	2,218	100.0%
BHH	6,224	0	-100.0%
Others	59	62	5.1%
Total	**321,269**	**355,937**	**10.8%**

Table 1B – Enrollment counts – FFS & Medicare Sharing Programs

	January 2015	September 2016	Percent Change
FFS	102	168	64.7%
Medicare Savings	3,718	3,945	6.1%
Total	3,820	4,113	7.7%

Table 2A - Benefits for QUEST Integration

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

Table 2B - Long-Term Care Services

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

Table 2C - Fee-For-Service Benefits

State of Hawaii Organ and Tissue Transplant
Dental

Table 3 - Carve-Out Services

The following additional carve-out services are available to Medicaid beneficiaries outside of the QI program.

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

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