Hawaii QUEST Integration

Annual Monitoring Report to CMS

Federal Fiscal Year 2020

Reporting Period:

October 1, 2019 - September 30, 2020

(Demonstration Year 26)

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I. Introduction

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI 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 reporting period, MQD continued to focus on a comprehensive internal quality improvement project, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. Weekly meetings were held through the federal fiscal year for the "HOPE Leadership Team" to ensure HOPE initiatives are weaved into the new QI Request For Proposal (RFP). On August 26, 2019, the new QI RFP was issued, which introduces an expanded care model to offer additional services for Hawaii's vulnerable population.

A total of 4 proposals were received for the QI RFP issued in August 2019. On January 22, 2020, MQD awarded to each of the plans that submitted a proposal. The new contract is scheduled to go into effect on July 1, 2020. On May 29, 2020, MQD rescinded the award and cancelled the RFP due to the COVID-19 pandemic. MQD plans to reissue a new QUEST Integration RFP in the first quarter of FFY 2021. MQD will modify the RFP requirements to reflect the new reality of the emerging needs of the Medicaid population in particular during a pandemic period.

This annual report meets the requirements of item *51 Monitoring Reports* in the Special Terms and Conditions (STC) document of Hawaii's section 1115 (a) Demonstration Waiver, as well as, the Managed Care Program report required under 42 CFR 438.66(e). Information on the fourth quarter of Federal Fiscal Year (FFY) 2020, that would ordinarily be provided in a separate report, is provided as distinct information within this annual report as Appendix J.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending September 30, 2020 was submitted by the November 30, 2020 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

During the reporting period, QUEST Integration Request For Proposal Supplemental Changes #12, #13, #14 and #15 were sent to CMS for approval on contract content changes, 2019 supplemental rate changes, for 2020 CAP rate and for extension of contract. CMS approved Supplemental Changes #12 and #13.

During this period, no additional or new health plans were contracted with for QI.

B. Benefits & Benefit Changes

Community Integration Services (CIS)

The CIS amendment to the current 1115 Demonstration waiver was approved on October 31, 2018. This amendment will increase access to CIS to individuals who are chronically homeless or in danger of losing public housing with either a physical or behavioral illness. MQD continues to work on provision of these services to eligible beneficiaries with providers and collaborative partners in the community. In March of 2020, MQD issued initial CIS policy guidance around data requirements for the CIS program. In September 2020, MQD shared draft CIS policy guidance around criteria, processes, and service codes with Health Plans and community partners with the intent of gathering feedback.

1115 Demonstration Renewal

MQD was awarded an extension of the QUEST Integration demonstration on July 31, 2019. MQD received approval for its existing expenditure and waiver authorities, with the exception of the waiver of retroactive eligibility rules. MQD had withdrawn its request to continue that policy in June 2019. MQD received additional expenditure authority to expand the set of CIS benefits available to beneficiaries. CMS also included new reporting requirements in the Special Terms and Conditions.

MQD submitted various documents related to the 1115 waiver during this time frame (October 1, 2019—September 30, 2020):

- On April 8, 2020 CMS approved Hawaii's request to update the Hawaii QUEST Integration (Project No. 11-W-00001/9) with the Emergency Preparedness and Response Attachment K in order to respond to the COVID-19 pandemic.
- On June 25, 2020 CMS approved the State of Hawaii's request for a Section 1115(a) Demonstration project to address the COVID-19 public health emergency. CMS approved expenditures for Retainer Payments, 1915(i)-like Initial Evaluations and Assessments, and Revaluations and Reassessments, and 1915(c) and 1915(c)-like HCBS Waiver Level of Care Determination and Redetermination Timeline**.** CMS also approved flexibilities around HCBS Visitor Requirements.
- On September 1, 2020 CMS approved Project No. 11-W-00001/9 Hawaii Behavioral Health Services Protocol submitted by Hawaii as required by the Special Terms and Conditions (STCs) of the demonstration.
- On September 25, 2020 CMS approved the update to the Hawaii QUEST Integration (Project No. 11-W-00001/9) Emergency Preparedness and Response Attachment K with an Addendum in order to respond to the COVID-19 pandemic.

HOPE initiative

MQD staff from across the various branches continue to work with our consultants, stakeholders and other parties to develop implementation plans for the initiatives outlined in our HOPE document and the MCO Request for Proposal. A primary focus has been on planning for implementation of advanced Health Homes, which will be known as “Hale Ola”, a new type of service delivery and coordination that was included in the MCO RFP. This has required intensive discussions with the HOPE leadership team and the consultants assigned to this task.

Another area of focus is on screening and addressing social risk factors for members with Special Health Care Needs. MQD received technical assistance from the State Health and Value Strategies Program and identified Hawaii-specific needs, priority domains (e.g., food and housing insecurity), and standardized screening questions.

Behavioral health integration across the continuum was also another area of focus. MQD researched best practices and meet with experts in the field with technical assistance support from the Center for Health Care Strategies.

MQD also spent a considerable amount of time identifying ways to streamline care coordination and improve outcomes for Special Health Care Needs and LTSS members receiving care coordination. Additionally, MQD was able to secure funding from the Stupsky Foundation for support to develop a specialized palliative care benefit that is community-based.

Department of Education (DOE) & School Based Services

Med-QUEST continues to partner with DOE and assist their staff with Medicaid billing issues to better enable them to appropriately bill Medicaid. This includes bi-weekly meetings, emails and written guidance to enable DOE to appropriately maximize Medicaid reimbursement for school-based medically necessary services.

DOE staff has continued to conduct mail outs and telephone calls to inform and receive necessary consent forms from parents to work with Medicaid for medically necessary services during school hours. The process has been more challenging due to multiple and varied barriers encountered along the way. In addition, the requirement for all providers to obtain an NPI be eligible for Medicaid reimbursement has also proven to be difficult. Despite these challenges, DOE successfully began billing for skilled nursing services November 1, 2019 and received their first reimbursement check shortly thereafter. During this period total federal reimbursement was over $500,000. This was the first time DOE received any federal reimbursement for nursing services since 2007. The DOE also increased their administrative support by hiring additional support staff and renewed their contract with UMass for claims processing with Medicaid and to receive assistance to implement Administrative claiming. Prior to the current Public Health Emergency (PHE) DOE was in the process of hiring a physician to assist with medical related issues, but that is now on hold indefinitely. Efforts to increase billing for other school-based services, as well as adding Administrative claiming for federal reimbursement, continue.

State Plan Amendments and Hawaii Administrative Rules

For the reporting period of 10/01/19 to 09/30/20, PPDO completed the following SPAs, and continues to work on other SPAs initiated during this period:

- 19-0004 “Recovery Audit Contractor (RAC) reimbursement increase” was approved by CMS on 10/29/19 which allows the current continency fee rate of 12.5 percent to increase to 17 percent for all RAC claims.

- 20-0001 “Optional State Supplementary Payment” was approved by CMS on 02/11/20 which a yearly required amendment to reflect the increase to the monthly income standards for Domiciliary Care Type I from $1,422.90 to $1,434.90 and for Domiciliary Care Type II from $1,530.90 to $1,542.90.

- 19-0006 “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act” was approved 03/04/20 and created a new section (K) to the State Plan that details claims review requirements, program to monitor antipsychotic medications by children, and fraud and abuse identification requirements for Hawaii.

- 19-0007 “Federally Qualified Health Center and Telehealth” was approved 03/07/20 to update the definitions of Spoke/Originating site and Hub/Distant site definitions, how the sites are used to deliver covered medical services through telehealth, health care provider requirements for telehealth and clarifies the payment methodology for these services.

- 20-0002 “COVID 19-Emergency” was approved 04/30/20 to create a new section in the State Plan which modified the public notice and tribal requirements, extends the reasonable opportunity period for immigration status verification and bed hold day allowances during the emergency period.

- 19-0005 “Durable Medical Equipment (DME) Fee For Service (FFS)” approved 07/23/2020 to meet section 1903(i)(27) to the Social Security Act requirements which prohibits federal Medicaid reimbursement to state for certain durable medical equipment (DME expenditures that are in aggregate, in excess of what Medicare would have paid for such items.

PPDO continues to work on amendment drafts for Hawaii Administrative rules.

Medicaid Eligibility Quality Control (MEQC) and Permanent Error Rate Measurement (PERM)

The Review Year (RY)2021 PERM is underway and PPDO is coordinating activities between the Department’s Eligibility staff and Booz Allen Hamilton (BAH), Eligibility Review Contractors (ERC) to meet requirements of the review process. The activity is high with request for clarification of KOLEA system rule processing, case information, and findings. In addition, PPDO has been instrumental in working with the Department’s Quality Control Office for required system data, access, policy updates, and training for the MEQC proposal which has been approved by CMS on December 31, 2020. Together with the KOLEA Project Team, PPDO is coordinating with QC in preparation for MEQC to commence simultaneously with the PERM RY2021. Logistics of the MEQC reviews are in process, however the basis will be on the accuracy and timely determination of current eligibility determinations for the Medicaid/CHIP programs for application, change of circumstances, and renewal approvals (ACTIVE actions). In addition, the MEQC focus includes reviews of denials and terminations (NEGATIVE actions). The required number of samples for the MEQC review year is as follows:

Program/Action Type	Number to Review
CHIP active	210
Medicaid (all others except LTC)	110
LTC only	100
Medicaid negative	210
CHIP negative	210

Policy and Program Directives

Policy and Program Directives (PPDs) are issued to MQD staff for information, clarifications and actions to be taken relative to any policy change ranging from changes in federal rules and policy to changes in state rules and regulations. For the reporting period, nine (9) PPDs were issued:

- **19-005** 10/23/2019
  RETROACTIVE MEDICAL ASSISTANCE FOR INDIVIDUALS UNDER QUEST INTEGRATION
- **19-006** 12/6/2019
  2020 MEDICARE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE AMOUNTS
- **19-007** 12/6/2019
  2020 SSA RSDI, SSI AND VA COST OF LIVING ADJUSTMENT INCREASE
- **19-008** 12/27/2019
  2020 SPOUSAL IMPOVERISHMENT STANDARDS AND HOME EQUITY LIMIT FOR LTC INDIVIDUALS
- **20-001** 1/23/2020
  TREATMENT OF REVOCABLE TRANSFER ON DEATH DEED (TODD)
- **20-002** 2/12/2020
  TREATMENT OF CENSUS WORKER INCOME
- **20-003** 3/16/2020
  2020 INCREASE IN THE RESOURCE LIMITS FOR THE MEDICARE SAVINGS PROGRAMS
- **20-004** 3/17/2020
  MEDICAL MASS CHANGE 03/20 DUE TO THE INCREASE IN THE FEDERAL POVERTY LEVELS FOR 2020
- **20-005** 9/21/2020
  DEATH PAYMENTS PROGRAM UNCLAIMED BODIES (State-only program. Not Medicaid related)

Provider Memos are issued to providers and posted on the Med-QUEST website for information, clarifications and actions to be taken relative to changes ranging from changes in federal rules and policy to changes in state rules and regulations. For the reporting period, forty-four (44) Provider/Health Plan memos were issued. Of note, this is more than what MQD would usually issue however, many were issued to respond to the COVID-19 pandemic.

QI Memos – 2020

QI-2032 - Medicaid Fee-For-Service Hospice Rates - Effective October 1, 2020 through September 30, 2021
QI-2031 - QUEST Integration (QI) Transition of Care (TOC) Files
QI-2030 - Medicaid Fee-For-Service Hospice Nursing Facilities Rates - Effective July 1, 2020
QI-2029 - HOKU COVID-19 Waivers and Policy Reminders
QI-2028 - Clarification on Applied Behavior Analysis (ABA) Services Through Telehealth
QI-2027 - Required Quantity Prescribed Field in Point of Sale Claim Submission for Schedule II Drugs
QI-2026 - Medicaid Rates for Legacy Hilo Rehabilitation and Nursing Center
QI-2025 - Universal Precautions for QUEST Integration Members Receiving At-Risk and Home and Community Based Services (Addendum to FFS-M15-05)
QI-2024 - Subacute Definitions (Replaces QI-2012, QI-2012A)
QI-2023 - Medicaid Rates for Island Skilled Nursing and Rehabilitation
QI-2022 - Medicaid Fee-For-Service Rates - Effective July 1, 2020
QI-2021 - Guidance on SARS-COV-2 Antibody Testing
QI-2020 - Coverage of Services for Autism Spectrum Disorder via Telehealth
QI-2019 - Updated DHS 1145 - Hysterectomy Acknowledgement Form and Rescinding 1146 - Sterilization - Consent Form Change
QI-2018 - Quality Portion of Auto-Assignment Algorithm for Quest Integration (QI) Members
QI-2016 - COVID-19 Pandemic Action Plan for QI Health Plans and Providers - Part IV
QI-2015 - COVID-19 Pandemic Action Plan for QI Health Plans - Part III
QI-2014 - COVID-19 Pandemic Action Plan for QI Health Plans - Part II
QI-2013 - Telehealth Guidance for Public Health Emergency - Telephonic Services and Services Billable by Qualified Non-Physician Health Care Professionals

QI-2012A - Subacute Definitions (Addendum)
QI-2012 - Subacute DefinitionsQI-2011A - Clarification of Items and Services Carved Out from the Long Term Care PPS Rates (Addendum)
QI-2011 - Clarification of Items and Services Carved Out from the Long Term Care PPS Rates
QI-2010 - Telehealth Guidance During Public Health Emergency Related to COVID-19QI-2009 - COVID-19 Pandemic Action Plan for QI Health Plans
QI-2008 - Federally Qualified Health Center Telehealth Guidance During Public Health Emergency Period in Response to COVID-19
QI-2007 - Tele-Health Payment Guidance for Federally Qualified Health Centers (FQHC)
QI-2006B - New Provider Enrollment System - HOKU System Update (Addendum)
QI-2006A - New Provider Enrollment System - HOKU System Update (Addendum)
QI-2006 - New Provider Enrollment System - HOKU System Update
QI-2005 - New State Medicaid ID Card Design
QI-2004 - Revised QUEST Integration Coverage for Our Care, Our Choice Act (End of Life Care Option)
QI-2003 - Community Integration Services (CIS) Data Requirements
QI-2002 - Payment Suspension to Provider (Philip Suh, MD) - Effective January 17, 2020

QI Memos – 2019

QI-1934 - Med-QUEST Guidance Regarding the Coverage of Routine Costs Associated with Qualifying Clinical Trials
QI-1933 - Medicaid Fee-for-Service Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC) Prospective Payment Rates (PPS) - Effective January 1, 2020 through December 31, 2020
QI-1932A - Medicaid Fee-for-Service REVISED Hospice Nursing Facility Rate for Hospice Hilo - Effective January 1, 2020
QI-1932 - Medicaid Fee-for-Service Hospice Nursing Facility Rate for Hospice Hilo - Effective January 1, 2020
QI-1931 - Medicaid Fee-for-Service Hospice Nursing Facility Rate for St. Francis - Effective January 1, 2020
QI-1930A - Medicaid Fee-for-Service REVISED Hospice Rates - Effective January 1, 2020 through June 30, 2020
QI-1930 - Medicaid Fee-for-Service Hospice Rates - Effective January 1, 2020 through June 30, 2020
QI-1929 - Electronic Visit Verification (EVV) Service Codes and Modifiers
QI-1928 - QUEST Integration (QI) Transition of Care (TOC) Files

C. Enrollment and Disenrollment

The Customer Service Branch (CSB), Eligibility Branch (EB), and Health Care Outreach Branch are committed to assist community members complete their Medicaid application and maintain enrollment. Prior to the public health emergency (PHE), Med-QUEST Division (MQD) administration planned to issue laptops with virtual personal network and install Voice Over Internet Protocol (VoIP) in EB offices on all islands. The enhancement in technology led a smooth transition for staff to work remotely at the onset of the PHE and more notably seamless continuation of service to beneficiaries. The decision proved effective as the State had a 31% increase in enrollment and any of the beneficiaries requiring staff assistance would have been assisted remotely using the new technology.

The application process ends with enrollment. It is the goal of MQD to obtain a QI health plan choice from every applicant. If applicant is not prepared to select a plan, MQD staff provides the names of QI health plans in the service area and encourages the individual contact his or her primary care physician to ask the name of the QI health plan the physician is a participating provider. In the absence of a selection, our system will auto-assign the beneficiary a QI health plan and generate a choice notice. The beneficiary has 90 days to choose another QI Health Plan. Otherwise, the beneficiary will remain enrolled in the auto-assigned QI Health Plan until the next annual plan

change period. Beneficiaries that regain Medicaid eligibility within 180 days from last covered will re-enroll in the last QI Health Plan recorded in HPMMIS.

1. Enrollment Summary

As of September 30, 2020, the following table represents the percentage increase of applications during the PHE.

Count	2019	2020	Percentage Increase in Applications
Honolulu	26,149	33,388	28%
Maui	5,784	9,138	58%
Hawaii	7,610	8,808	16%
Kauai	2,598	4,061	56%
Statewide	42,141	55,395	31%

The 2019 QUEST Integration Annual Plan Change was October 1 through 31, enrollment applied January 1, 2020. A total 321,027 beneficiaries were eligible to participate in annual plan change. Of the total enrollees, 10,626 (3.31%) beneficiaries elected to enroll in a different health plan for the 2020 benefit year (January to December 2020). The table below is a summary of the annual plan change activity by health plan and service area. The numbers reflect new members each plan gained January 1, 2020.

MAGI Excepted	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	74	7	24	18	2	0	125
HMSA	254	21	91	34	2	0	527
Kaiser	73	0	0	35	0	0	510
Ohana Health Plan	75	2	28	5	3	0	221
UnitedHealthcare Community Plan	385	5	53	20	0	0	576
Total	**861**	**35**	**196**	**112**	**7**	**0**	**1959**
Beneficiaries w/APC Choice	1.58%	0.06%	0.36%	0.21%	0.01%	0.00%	3.59%
MAGI	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	420	67	147	108	34	6	782
HMSA	1411	173	525	194	13	6	3104
Kaiser	598	0	0	288	0	0	3208
Ohana Health Plan	126	14	92	24	3	0	1145
UnitedHealthcare Community Plan	122	8	28	10	1	0	428
Total	2677	262	792	624	51	12	8667
Beneficiaries w/APC Choice	1.00%	0.10%	0.30%	0.23%	0.02%	0.00%	3.25%

[*Member Choice of Health Plan Exercised*, appears in section XII.A.]

2. Disenrollment Summary

There were 226 clients that changed health plans outside the normal change period.

D. Quality of Care

Information related to quality of care can be found in the following sections: IV, *Grievances, Appeals & State Fair Hearings*; XIV, *Quality Assurance and Monitoring Activity*; and XV, *Quality Strategy Impacting the Demonstration*.

E. Access that is Relevant to the Demonstration

The COVID-19 Public Health Emergency (PHE) affected Member ability to access in-person care. To address this, MQD applied for and received federal flexibilities that mitigated some of the impact of COVID-19. Many policy decisions were made to further increase the access to care, including several telehealth adjustments and flexibilities. Provided below are some actions MQD took to meet other challenges affecting Members and access to care presented by the COVID-19 PHE.

Increased Collaboration and Communication with Health Plans

Beginning May 2020, MQD met with all five QI Health Plans on a weekly basis. These meetings were named "COVID Task Force Meetings", and the focus was addressing PHE issues.

Memorandum to Promulgate the Flexibilities Approved by CMS

MQD received approval on Appendix K which allowed the following flexibilities of services delivered during the PHE period.

a. Telehealth
   Instead of face-to-face visits, telehealth played an important role for continuance of service delivery.

b. Administering Level of Care Assessments
   MQD auto-extended 6 months on the level of care assessments without face-to-face visits for those receiving HCBS services residing in their own home. The level of care assessment for Medicaid beneficiaries residing in facilities for other community settings continues to receive face-to-face level of care assessments. Also, levels of care services were maintained and not reduced.

c. CCS Flexibilities
   The face-to-face requirements for CCS level 5 Members remained the same. However, telehealth visits were allowed for CCS Members in levels 1 through 4, and face-to-face visits for those Members were required on an as-needed basis.

d. Adult Day Care Flexibilities
   MQD allowed for the continuation and maintenance of payments to adult day care facilities while services to Members were modified, such as wellness calls and check-ins, delivery of groceries and meals, translation, and family support.

Addressing Prevention of COVID-19

a. Preventative Personal Protection Equipment (PPE) Distribution
   MQD partnered in the early months of the pandemic with State emergency agencies to obtain and distribute scarce PPE for EARCHs, CCFFHs, DD facilities, and CMAs. These congregate settings care for some of the most vulnerable populations in Medicaid who are at the highest risk for mortality from COVID-19. Along with the PPE, webinars and printed handouts were shared with facility owners to

educate and support them on proper PPE usage and disease prevention. Additionally, MQD worked with the State of Hawaii Office of Health Care Assurance (OHCA) to align communications with the facilities that received the PPE. As a result, the State of Hawaii experienced one of the lowest death rates for COVID-19 nationwide.

b. Go-Kits

Similar to the preventative PPE distribution, Go-Kits were specifically designed for the congregate settings when care givers or Members became positive for COVID-19. Each Go-Kit includes a box of gloves, face shields, gowns, surgical masks, booties, and the instructions for proper use. Each Go-Kit was designed for single-Member care and multiple Go-Kits were delivered for settings that had multiple Members. There were 375 Go-Kits created internally by MQD staff and 75 were distributed to 31 congregate settings during the second half of 2020. MQD partnered with CMAs, Health Plans and internal staff to ensure Go-Kit availability on all islands. In the event an individual became positive, the case manager was notified, and immediate actions were taken to deliver appropriate Go-Kits to that setting. As a result of the strategic plan, Go-Kit deliveries were often made within hours of such notification.

Additionally, Health Plans collaborated to design and create additional Go-Kits for HCBS Members that reside in their own homes. Health Plan service coordinators were notified when a Member or in-home care giver became COVID-19 positive and quickly delivered a Go-Kit to that home. There were 652 Go-Kits created by the Health Plans, and 381 were distributed to homes during the second half of 2020.

Equipping Providers to Deliver Telehealth – Laptop Distribution

MQD applied for an emergency Advance Planning Document (APD) and received approval for funding to purchase laptop and surface devices to distribute to targeted Medicaid providers to facilitate and increase services delivered via telehealth, especially in rural areas. MQD distributed 217 devices to 20 providers on the islands of Oahu, Kauai, Maui, Molokai and Hawaii.

F. Pertinent Legislative or Litigation Activity

MQD continues to be a party to a lawsuit along with the Children and Adolescent Mental Health Division, Dept. of Health for the provision of mental health services for a child/young adult.

The 2020 Legislative session was cut short because of COVID-19. Major policy initiatives were not addressed by the legislature, as the primary focus was on passing required funding bills.

MQD is pursuing litigation regarding a drug, Plavix, for which MQD believes the manufacturers withheld critical information on drug efficacy as it relates to patient ethnicity. Several key MQD employees were deposed in the 2nd quarter of FFY 2020. This case was scheduled to go to court in the 1st quarter of FFY 2021.

G. Public Forums

Due to the COVID-19 pandemic emergency, there was only one public forum set up during this reporting period. On January 30, 2020, MQD held an award public forum to solicit meaningful comments on the progress of the Federal approval of the State's Section 1115 Waiver Demonstration. The five-year demonstration project, which is administered by the Department of Human Services, Med-QUEST Division (MQD), authorizes Hawaii to continue providing Medicaid benefits through its managed care delivery system, continue providing Home and Community-

Based Services to certain populations, and expand access to and benefits of Community Integration Services for beneficiaries who meet specified needs-based criteria. This demonstration project is approved through July 31, 2024.

IV. Grievances, Appeals and State Fair Hearings

A. Grievance Events that Affected Health Care Delivery

See section IV.B, *Information on and Assessment of Grievances and Appeals for the Managed Care Program*, below.

B. Information on and Assessment of Grievances and Appeals for the Managed Care Program

1. Grievances

The managed care health plans have policies, procedures, and systems for logging, tracking, and reporting appeals and grievances. The health plans have grievance coordinators who manage member grievances and interface with other departments in the process of investigating and responding to members. It was found that the health plans were timely in their acknowledgment and resolution letters to members. Letters were written at or below a 6.9 grade reading level and were based on templates required by MQD to communicate grievance acknowledgements and dispositions to the members.

It appears that members have been exercising member grievance rights and the Health Plans are striving to be on time with acknowledgement and resolution letters with a few exceptions. If a member is not satisfied with the health plan's grievance decision, the member has been given the information on how to file a state grievance review with DHS/MQD. The grievance review determination made by DHS/MQD is final.

2. Appeals

The managed care health plans have policies, procedures, and systems for logging, tracking, and reporting appeals. The health plans have appeals coordinators that interface with the authorization and referral management, pharmacy management, and the medical director to make appeal decisions and respond to members. Individuals making appeal decisions have the appropriate credentials and were not involved in the initial decision. The health plans met timeliness requirements for the acknowledgement and resolution letters with a few exceptions.

3. State Fair Hearings (Administrative Hearings)

Requests for a State Administrative Hearing are disseminated by the Administrative Appeals Office (AAO) to MQD. Members must first exhaust the appeal system of the Health Plan before they can request a State Administrative Hearing with the AAO. It appears that members have been exercising their appeal rights and have made requests for administrative hearings.

C. Member Grievances and Appeals Filed During the Reporting Period by Type

The following tables provide information on the grievances and appeals received during this reporting period.

1. Grievances to MQD Health Care Services Branch (HCSB)

October 2019 – September 2020 Types of Member Grievances to MQD (HCSB)	
Description: The following are grievances received by the HCSB of MQD. These DO NOT include the grievances received by the Health Plans, which are reported in a separate table below.	
Health Plan Policy	3
Provider/Provider Staff Behavior/Services	31
Transportation Customer Service	8
Treatment Plan/Diagnosis	5
Fraud and Abuse of Services	2
Billing/Payments	5
Member Rights	21
Medication	6
General Information	36
Forward to Other Departments	27
Total	**144**

Month	# of Member Grievances Addressed by HCSB
October 2019	9
November 2019	5
December 2019	11
January 2020	8
February 2020	7
March 2020	17
April 2020	15
May 2020	16
June 2020	13
July 2020	15
August 2020	16
September 2020	12
Total	**144**

Status of Member Grievances Addressed by HCSB					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul–Sep 2020	**TOTAL**
Received	7	7	44	43	101
Status					
Referred to Subject Matter Expert	0	0	10	16	26
Health Plan resolved with Members	2	0	17	16	35
Member withdrew grievance	0	1	0	0	1
Resolution in Health Plan favor	0	1	7	7	15
Resolution in Member's favor	1	4	2	2	9
Still awaiting resolution	2	2	0	0	4
Carry-over from previous Quarter	2	6	13	13	34

2. Grievances to Health Plans

Types of Member Grievances Reported to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul–Sep 2020	
Medical					**TOTAL**
Provider Policy	3	7	10	6	26
Health Plan Policy	20	26	23	35	104
Provider/Provider Staff Behavior	74	70	79	72	295
Health Plan Staff Behavior	49	32	35	32	148
Appointment Availability	4	9	10	7	30
Network Adequacy/ Availability	2	1	3	4	10
Waiting Times (office, transportation)	60	90	53	59	262
Condition of Office/ Transportation	2	0	4	4	10
Transportation Customer Service	19	18	11	13	61
Treatment Plan/Diagnosis	14	16	24	34	88
Provider Competency	40	25	13	20	98
Interpreter	0	0	0	0	0
Fraud and Abuse of Services	2	1	4	2	9

Billing/Payments	19	17	22	19	77
Health Plan Information	12	20	10	8	50
Provider Communication	24	22	15	17	78
Member Rights	5	9	19	20	53
Total	349	363	335	352	1399

Some members had multiple areas that need to be addressed within their one grievance report to MQD.

Status of Member Grievances Reported to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Total number filed during the reporting period	325	334	268	287	1,214
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	319	328	262	278	1,187
Total number not receiving timely acknowledgement from health plan	6	6	6	3	21
Total number expected to receive timely acknowledgement during next reporting period	0	2	0	9	11
Total number that received timely decision from health plan	308	324	246	268	1,146
Total number not receiving timely decision from health plan	11	6	16	1	34
Total number expected to receive timely decision during next reporting period	7	6	15	7	35
Total number currently unresolved during the reporting period	13	9	19	18	59

3. Appeals to Health Plans

There was a total of 1,337 appeals submitted for FFY 2020 with the health plans. Of those appeals submitted to the health plans, only 24 appeals were submitted with the Administrative Appeals Office. There were 19 resolved with the health plan or decided in Member's favor prior to going to a hearing. There was 1 resolved in DHS's favor.

Types of Member Appeals to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Service denial	78	76	64	43	261
Service denial due to not a covered benefit	54	45	56	9	164

Service denial due to not medically necessary	211	238	177	241	867
Service reduction, suspension or termination	2	0	2	0	4
Payment denial	18	9	12	8	47
Timeliness of service	0	0	0	0	00
Prior authorization timeliness	0	0	0	0	00
Other	0	10	4	4	18

Status of Member Appeals to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Total number filed during the reporting period	355	374	308	300	1337
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	318	362	304	269	1253
Total number not receiving timely acknowledgement from health plan	37	11	2	9	59
Total number expected to receive timely acknowledgement during next reporting period	24	1	2	22	49
Total number that received timely decision from health plan	321	349	270	265	1205
Total number not receiving timely decision from health plan	30	15	24	2	71
Total number expected to receive timely decision during next reporting period	28	24	32	33	117
Total number currently unresolved during the reporting period	28	24	32	33	117
Total number overturned	205	238	174	168	785

4. Appeals to the State (State Fair Hearings)

Types of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Medical	2	3	5	4	14
Home and Community Based Services (HCBS)	0	2	1	1	4
Van Modification	0	0	0	0	0
Applied Behavioral Analysis (ABA)	0	0	0	0	0
Durable Medical Equipment	0	0	0	0	0
Reimbursement	0	0	0	0	0
Medication	1	0	0	1	2
Miscellaneous	2	1	1	0	4

Status of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Submitted	5	6	7	6	24
Status received from AAO					
Department of Human Services (DHS) resolved with health plan or Department of Health Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing	2	5	7	5	19
Dismiss as untimely filing	0	0	0	0	0
Member withdrew hearing request	1	0	0	0	1
Resolution in DHS' favor	0	1	0	0	1
Resolution in Member's favor	0	0	0	0	0

Still awaiting resolution	2	0	0	1	3

V. Adverse Incidents

A. Long Term Services and Supports (LTSS)

In FFY 2020, a total of 1,406 adverse events related to the LTSS population were reported. The top five incident categories were: Fall, Hospital, Death, Emergency Room Visit, and Injury. Falls were the top occurring incident for all quarters. Hospitalization was the second most occurring incident.

There were 52 adverse events from Nursing Facilities. "Fall" remains the top occurring incident for all quarters in Nursing Facilities and "injury" was the second most occurring incident.

In ICF DD/ID there were 43 adverse events. "Emergency Room Visits" were the top occurring incident for all quarters in ICF DD/ID and "injury" was the second most occurring incident.

The LTSS category includes a number of different provider types such as Community Care Foster Family Homes (CCFFHSs), Extended Adult Residential Care Homes (EARCHs), nursing facilities and Developmental Disability and Intellectual Disability (DD/ID) facilities. The following provides greater detail on the adverse incidents reported to MQD by the nursing facilities for the reporting period.

Developmental Disability and Intellectual Disability (DD/ID) facilities are not included in the LTSS category. The table below provides the adverse incidents reported to MQD by intermediate care DD/ID facilities for the reporting period.

Types of Adverse Events												
	Health Plan				Nursing Facility				ICF DD/ID			
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
Fall	136	142	120	132	10	10	12	10	0	2	0	1
Hospital	71	90	96	104	0	0	0	0	0	0	0	0
Death	29	35	27	32	0	0	0	0	0	0	1	0
Emergency Room Visit	70	62	51	55	0	0	0	0	9	10	4	5
Injury	31	34	45	44	2	1	4	3	5	1	0	4

Med Error	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	337	363	339	367	12	11	16	13	14	13	5	11

VI. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data

MQD shares an MMIS system with the Arizona Heath Care Cost Containment System (AHCCCS); the encounter intake and validation systems are structured similarly, and enhancements and modifications are generally operationalized simultaneously for both states. However, AHCCCS has achieved better encounter data quality than Hawaii. During FFY 2020, Med-QUEST Division ramped up its efforts related to the improvement of encounter data quality in multiple ways.

First, MQD contracted with Hawaii's EQRO to conduct an Encounter Data Validation (EDV) study. The study continues into FFY2021 and will provide MQD with an environmental scan of best-practices in encounter data quality; a Hawaii-specific analysis of current data quality issues parsed by MCO; and actionable recommendations for improving encounter data quality that MQD will plan to implement in FFY2021. Simultaneously, MQD sought additional funds from CMS within its MMIS OAPD to fortify its ability to address and implement the recommendations from the EDV Study. These funds are expected to strengthen MQD's policy and system documentation, improve facilitation and resolution of ongoing encounter data issues with MCOs, and support the development of an action plan to systematically improve encounter data quality.

Second, MQD conducted a monthly encounter validation meeting with all participating MCOs throughout the year to address major issues in encounter data submission or validation. Ongoing engagement supported a continuous data quality improvement initiative aimed at decreasing the number of encounters that fail system edits. MQD also continued to refine an encounter reconciliation process directly with the MCOs that accounted for financial discrepancies between encounters submitted by the MCOs and accepted by MQD. The protocol for this reconciliation process has undergone iterative improvements, and the reconciliation is conducted at least twice per year.

Third, MQD began work to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. For example, MQD worked with its contracted actuary, Milliman, to refine its reconciliation process to align with the data submission to the actuary, that would enable an apples-to-apples comparison between encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. The new aligned encounter reconciliation is expected to be released in FFY2021. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.

Fourth, in addition to encounter data reconciliation, MQD worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing for high-cost newborns is exclusively based on encounters found within the State Medicaid encounter system. Beginning in CY2019, risk sharing for high-cost drugs was implemented to be based on

encounters found within the State Medicaid encounter system. In CY2020, Milliman began additional beneficiary-level verifications to ensure that any special services were only offered to those identified to be qualifying for these services by MQD.

VII. Action Plans for Addressing Issues Identified In:

A. Policy

During the reporting period, no policy issues were identified for any action plans.

B. Administration

MQD's Ombudsman contractor failed to comply with several contract requirements. MQD did not extend the current contract but re-procured and awarded the Ombudsman contract to a new contractor effective October 2020. The new contractor has been complying with the contract requirements.

C. Budget

See section IX, *Financial and Budget Neutrality Development and Issues*, below.

VIII. Expenditure Containment Initiatives

See section XVIII.F (Progress on Implementing Cost Containment Initiatives) below.

IX. Financial and Budget Neutrality Development and Issues

Throughout the year, there were no significant issues identified, so no corrective action plans were necessary.

X. Yearly Enrollment Reports for Demonstration Participants for the Demonstration Year

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**10/2019 - 9/2020**	**As of 9/30/20**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	1,411,919	119,705
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	427,328	36,527
Aged	Aged w/Medicare Aged w/o Medicare	343,517	29,523
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	286,914	24,298
Expansion State Adults	Expansion State Adults	1,199,295	107,098
Newly Eligible Adults	Newly Eligible Adults	254,768	22,195
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	6,717	604
CHIP	CHIP (HI01), CHIPRA (HI02)	351,023	27,921
Total		4,953,317	367,871

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	210,657
Title XXI funded State Plan	27,921
Title XIX funded Expansion	129,293
Enrollment current as of	9/30/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/20
EG 1 – Children	115,913	115,815	115,048	114,928	114,914	113,974	116,233	123,445	120,131	121,178	123,006	124,051	1,418,636
EG 2 – Adults	34,278	34,127	33,803	33,524	33,662	33,183	34,182	38,758	37,328	37,542	38,316	38,625	427,328
EG 3 – Aged	27,747	27,853	28,269	27,833	27,999	28,138	28,370	29,067	29,493	29,304	29,639	29,805	343,517
EG 4 – Blind/Disabled	23,628	23,782	23,786	23,465	23,647	23,654	22,935	24,340	24,452	24,341	24,348	24,536	286,914
EG 5 – VIII-Like Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EG 6 – VIII Group Combined	111,838	112,781	113,390	114,025	112,866	111,971	114,440	132,086	129,095	129,978	134,761	136,832	1,454,063

(Entries of “n/a” indicate that the State of Hawaii does not report on the eligibility group.)

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/20
State Plan Children	115,400	115,283	114,513	114,383	114,369	113,413	115,678	122,868	119,563	120,593	122,415	123,441	1,411,919
Sate Plan Adults	34,278	34,127	33,803	33,524	33,662	33,183	34,182	38,758	37,328	37,542	38,316	38,625	427,328
Aged	27,747	27,853	28,269	27,833	27,999	28,138	28,370	29,067	29,493	29,304	29,639	29,805	343,517
Blind or Disabled	23,628	23,782	23,786	23,465	23,647	23,654	22,935	24,340	24,452	24,341	24,348	24,536	286,914
Expansion State Adults	91,755	92,632	92,641	93,149	92,479	91,860	94,837	110,123	107,445	107,967	111,398	113,009	1,199,295
Newly Eligible Adults	20,083	20,149	20,749	20,876	20,387	20,111	19,603	21,963	21,650	22,011	23,363	23,823	254,768
Optional State Plan Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Foster Care Children, 19-20 years old	513	532	535	545	545	561	555	577	568	585	591	610	6,717
Medically Needy Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Demonstration Eligible Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Demonstration Eligible Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VIII-Like Group	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental LTC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Private	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

(Entries of “n/a” indicate that the State of Hawaii does not report on the eligibility group.)

C. Enrollment in Behavioral Health Programs

Point-in-Time (1st day of last month in reporting quarter)

Program	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Enrollment			
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,321**	**4,335**	**4,541**	**4,682**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**901**	**837**	**889**	**818**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,138**	**1,012**	**955**	**874**

D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) enrollment reported by the health plans is as follows.

1st Quarter Health Plan	Oct 2019	Nov 2019	Dec 2019
Aloha Care	442	486	669
HMSA	709	705	720
Kaiser	279	288	311
Ohana	2958	2901	2810
United Healthcare	2226	2196	2473
Total	**6614**	**6576**	**6983**

2nd Quarter Health Plan	Jan 2020	Feb 2020	Mar 2020
Aloha Care	538	525	644
HMSA	712	718	723
Kaiser	301	297	302
Ohana	2795	2708	2674
United Healthcare	2323	2210	2233
Total	**6669**	**6458**	**6576**
3rd Quarter Health Plan	**Apr 2020**	**May 2020**	**Jun 2020**
Aloha Care	645	519	509
HMSA	729	733	728
Kaiser	301	320	312
Ohana	2724	2689	2581
United Healthcare	2216	2191	2040
Total	**6615**	**6452**	**6170**

4th Quarter Health Plan	Jul 2020	Aug 2020	Sep 2020
Aloha Care	541	566	507
HMSA	744	759	680
Kaiser	301	307	306
Ohana	2717	2611	1874
United Healthcare	2209	2177	2089
Total	**6512**	**6420**	**5456**

Plan-to-plan change requests and results, specifically for LTSS members, are not tracked. The QI program includes LTSS services amongst its benefits.

XI. Outreach and Innovative Activities

The Health Care Outreach Branch (HCOB) actively planned and prepared for the Annual Medicaid Enrollment system (KOLEA) and Health Insurance Marketplace training to approximately 120 “Kōkua” (outreach/enrollment assisters), in-person assisters from Federally Qualified Health Centers (FQHC’s), Med-QUEST Kōkua Services Contractors, and other community health centers statewide. Trainings occurred on all islands, and covered details on how to submit online applications and upload documents in our KOLEA system via their Navigator Portal along with review of the Federal Health Insurance Marketplace application details.

Significant work through the year continued in identifying and assisting hard to reach populations and those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers, justice-involved populations and those who are admitted to and discharged from public institutions such as the Hawaii State Hospital.

2020 was a challenging year with the Covid-19 Public Health Emergency, Hawaii’s stay at home orders in March and all of the business within our State which closed permanently or laid off employees due to the pandemic. HCOB had to think outside the box and do outreach in creative ways while following stay-at-home orders and still being able to assist the community and get the work out. HCOB reached out to all food distribution entities, Department of Education Grab-N-Go breakfast and lunch programs, local labor unions, churches, etc. to distribute either hard or soft copy flyers so the community would know where to get help if they lost their health coverage, due to loss of work and employer sponsored health coverage. Our team arranged with unions, hotels, airlines, restaurants and other business to hold online informational sessions to educate employees on how to obtain health coverage for Medicaid and/or the Federal Health Insurance Marketplace for those who would be losing the employment and health coverage.

HCOB also noted, due to the Covid-19 pandemic, an uptick in those transitioning in and out of the Hawaii State Hospital along with justice-involved populations and experienced an increase of suspension/unsuspension requests from members for their Medicaid coverage.

XII. Number of Participants who Chose an MCO and Number of Participants who Changed Plans After Auto-Assignment

A. Member Choice of Health Plan Exercised

Number of Members	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020	Total
Individuals who chose a health plan when they became eligible	741	922	2,127	2,251	6,341
Individuals who were auto-assigned when they became eligible	7,406	6,850	10,717	9,641	34,614
Individuals who changed their health plan after being auto-assigned	2,611	2,395	5,027	3,869	13,902
Individuals who changed their health plan outside of choice period	65	76	43	42	226
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	18	6	9	13	46

During this reporting period, 6,341 individuals chose their health plan when they became eligible, and 13,902 changed their health plan after being auto-assigned. Also, 34,614 individuals had an initial enrollment which fell within this reporting period.

In addition, 46 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

XIII. Demonstration Evaluation and Interim Findings

During FFY2020, MQD prioritized revisions to the 1115 demonstration evaluation design to satisfy CMS requirements. MQD's 1115 demonstration evaluation design was approved by CMS on 10/15/2020. Upon approval, MQD's work with the UH Evaluation Team has transitioned to planning for data collection. The planning work and orientation of the UH Evaluation Team to MQD data will continue into FFY2021.

MQD submitted the "Hawaii COVID-19 Public Health Emergency Demonstration - Draft Evaluation Design - September 2020" on September 24, 2020 to the CMS Submission Portal and is currently awaiting feedback.

XIV. Quality Assurance and Monitoring Activity

A. Quality Activities

The External Quality Review Organization (EQRO) oversees the health plans for the Quest Integration (QI) and Community Care Services (CCS) programs. Health Services Advisory Group (HSAG), the EQRO, performed the following activities this Demonstration Year:

1. Validation of Performance Improvement Projects (PIPs)

Per Hawaii's Quality Strategy, each health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.330(b)(1) and §438.330(d)(2)(i-iv). The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

And, as one of the mandatory EQR activities required under the Balanced Budget Act, the EQRO conducted annual validation of these PIPs. The EQRO completed their validation through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (the PIP protocol).
The primary objective of the PIP validation was to determine the health plans' achievement of PIP module criteria, including:

- Integration of quality improvement science.
- Formation of teams.
- Setting aims.
- Establishing measures.

Towards the end of 2019, the EQRO initiated validation activities for the following 12 new PIPs to be submitted by the Hawaii Medicaid health plans:

1. For three QI health plans (AlohaCare, HMSA and KFHP)
    - Improving Adolescent WellCare Visits
    - Follow-Up After Hospitalization for Mental Illness.

2. For one QI health plan (Ohana)
    - Improving Rates for Adolescent Well-Child Visits
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

3. For one QI health plan (UnitedHealthcare)
    - Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center
    - Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64

4. For CCS
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge
    - Follow–Up After Emergency Department Visit for Mental Illness.

HSAG's validation of PIPs includes the following two key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of PDSA cycles, and sustainability and spreading successful change. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved and sustained.

HSAG evaluations were for the 2020 validation cycle. The core components of this standard approach involve testing changes on a small scale—using a series of 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.

Health Plan PIP results are provided in section XVIII.M, *Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions*, below.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

Validation of performance measures (PMs).

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the HEDIS 2020 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.1- The audit procedures were also consistent with the CMS protocol for performance measure validation: CMS External Quality Review (EQR) Protocols.1- The health plans that contracted with the MQD

during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' IS capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2019 (January 1, 2019, through December 31, 2019), and the audit activities were conducted concurrently with HEDIS 2020 reporting.

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 17 measures, yielding a total of 52 measure indicators, for the QI population. 'Ohana CCS was required to report on 8 measures, yielding a total of 20 measure indicators, for the CCS program. The measures were organized into the following five categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

- Access and Risk-Utilization
- Children's Preventive Health
- Women's Health
- Care for Chronic Conditions
- Behavioral Health

HSAG evaluated each QI health plan's compliance with NCQA IS standards during the 2020 NCQA HEDIS Compliance Audit. All QI health plans were Fully Compliant with the IS standards applicable to the measures under the scope of the audit. Overall, the health plans followed the NCQA HEDIS 2020 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of Reportable. Summarized results can be found on the MQD website under the tabs "Resources", and then "Quality Strategy".

3. Compliance Monitoring Review

COVID-19 Impact

Due to guidelines outlined by President Trump's declaration of a national emergency in March 2020 in response to the coronavirus disease 2019 (COVID-19) outbreak in the United States and travel restrictions in the State of Hawaii, the on-site portion of the EQRO's review of the health plan's compliance with standards was changed to a virtual site review utilizing the Webex meeting platform.

2020 is the second year of the three-year review cycle of EQR compliance reviews. HSAG performed a desk review of documents, file reviews, and a virtual site visit that included reviewing additional documents and conducting interviews with the QI health plans and the CCS program.

HSAG evaluated the degree to which QI health plans and CCS program complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to eight selected standard areas.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

During this reporting period, the Adult CAHPS survey for both Medicaid and CHIP was conducted. Results were provided to MQD at both the plan-specific and statewide aggregate report levels and are summarized later in this report in section XVIII.H, *CAHPS Survey*, below.

The standardized survey instrument selected was the CAHPS 5.0H Adult Medicaid Health Plan Survey. Adult members completed the surveys from February to May 2020. All sampled members received an English version of the survey with the option to request a survey in one of the four alternate, non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.

5. Provider Survey

Due to COVID-19 and HSAG's findings of other states receiving only 2% Response Rate on this survey, MQD decided to postpone this activity this year and to resume in January 2021 with the hope of getting a higher response rate and more meaningful results.

XV. Quality Strategy Impacting the Demonstration

During this reporting period, MQD contracted with a vendor, Myers Stauffer, to assist with updating MQD's quality strategy. MQD's quality strategy will follow the pillars outlined in the HOPE Vision document. In September 2020, MQD issued the quality strategy for public comment. Feedback indicated overall acceptance of the quality strategy. MQD was on track to present a revised quality strategy to CMS in the 1st quarter of FFY 2021.

XVI. Total Annual Expenditures for the Demonstration Population for the Demonstration Year

Please see Attachment C: Schedule C, Quarter Ending September 30, 2020.

XVII. Expenditures for Uncompensated Care Costs

Please see Attachment C: Schedule C, Quarter Ending September 30, 2020.

XVIII. Managed Care Delivery System

A. Accomplishments

Due to all of the interventions for the COVID-19 pandemic (some examples are provided above in section III.E, *Access that is Relevant to the Demonstration*), Hawaii experienced a decrease in the death rate of the elderly population. Factors contributing to this were, heightened infection control, PPE direct distribution and limiting community contact within the HCBS settings.

B. Status of Projects

During this reporting period, MQD completed the following projects.

1. National Take Back Initiative to receive unused or expired medications.
2. The new QI RFP scope of services

The following are on-going projects that MQD continues to make progress in.

1. Creation of a new RFP guidance manual for QI Health Plans
2. Going Home Plus project
3. Electronic Visit Verification (EVV)
4. Medicaid Provider Management System Upgrade (PMSU) – "HOKU" (Hawaii's Online Kahu Utility); HOKU in Hawaiian means, guiding star; Kahu in Hawaiian means caretaker, pastor, or one who looks after their flock
5. Additional My Choice My Way outreach and training
6. Collaborating with DOH and revising the Hawaii Administrative Rules for HCBS settings to comply with the HCBS Final Rules
7. Medicaid provider revalidation
8. Medicaid Information Technology Architecture (MITA) update
9. Community Care Services (CCS) on-site case management agency audits
10. Health Information Technology (HIT) investments
11. Department of Health (DOH) Immunization Record System
12. New Care Model design and planning
13. Maintenance of new Health Analytics Office (HAO) to analyze health plan data for quality assurance and performance improvements

C. Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State

Due to the COVID-19 pandemic, on-site audits were restricted. Any issues identified were addressed by desk-review and on an as-needed basis. Case studies were conducted virtually. There were no major outstanding findings to remediate.

D. Findings of Interim Evaluations

See section XIII, *Demonstration Evaluation and Interim Findings*.

E. Utilization Data

Calendar Year (CY) 2019 incurred aggregated health care expense data produced by our actuaries for our QI program is included as Attachment I. This data is aggregated for all of the MCOs. It is broken out by family and children, expansion, and the Adult, Blind and Disabled (ABD) population groups.

F. Progress on Implementing Cost Containment Initiatives

Discharge Planning for Difficult-to-Place Members

MQD continues to work with Hawaii Queen's Hospital on placement of difficult to discharge members. Such members often have substance abuse issues, behavioral health issues, non-compliance issues, morbid obesity, and homelessness. So far, Queen's Hospital expanded their coalition working with the Department of Public Safety, Honolulu police department, homeless shelters and agencies, and managed care organizations. The Queen's Coalition project is ongoing and continues to be successful in stabilizing members medical conditions as well as housing issues.

One Key Question

One Key Question is an on-going screening program to address pregnancy options for women of child-bearing age. The goal is to both reduce unwanted pregnancies and promote healthy newborn outcomes. The One Key Question is: "Would you like to become pregnant in the next year?"

Community Integration Services (CIS)

MQD continues to work with health plans on implementing the beginning stages of CIS services to their members. MQD also works with providers and collaborative partners in the community on providing these services to eligible beneficiaries. More CIS information can be found in III.B, *Benefits and Benefit Changes.*

G. Progress on Policy and Administrative Difficulties in the Operation of the Demonstration

See sections III.B, *Benefits and Benefit Changes*, and III.E, *Access that is Relevant to the Demonstration*.

H. CAHPS Survey

[Information on CAHPS activities performed during the reporting period, is provided above in section XIV.A.4, *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*.]

Summary of Statewide Comparisons Results

Comparison of the QI health plans' scores to the 2019 NCQA adult Medicaid national averages revealed the following summary results:

- AlohaCare QI did not score at or above the 90th percentile on any of the measures. Conversely, AlohaCare QI scored below the 25th percentile on two measures: Getting Needed Care and Getting Care Quickly.

- HMSA QI did not score at or above the 90th percentile on any of the measures. Conversely, HMSA QI scored below the 25th percentile on seven measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, and Coordination of Care.
- Kaiser QI scored at or above the 90th percentile on five measures: Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Coordination of Care. Also, KFHP QI did not score below the 25th percentile on any of the measures.
- ‘Ohana QI did not score at or above the 90th percentile on any of the measures. Conversely, ‘Ohana QI scored below the 25th percentile on one measure, Customer Service
- UHC CP QI scored at or above the 90th percentile on one measure, Coordination of Care. Conversely, UHC CP QI scored below the 25th percentile on two measures: Getting Needed Care and Getting Care Quickly.

Summary of Plan Comparisons Results

Comparison of the QI health plans for Service, and Coordination of Care revealed the following summary results:

- AlohaCare QI did not score statistically significantly lower or higher than the QI Program aggregate on any measure.
- HMSA QI scored statistically significantly lower than the QI Program aggregate on three measures, Getting Needed, Customer Service and Coordination of Care
- Kaiser QI scored statistically significantly higher than the QI Program aggregate on five measures; Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service and Coordination of Care
- ‘Ohana QI scored statistically significantly higher than the QI Program aggregate on one of the measures, Getting Care Quickly
- UHC CP QI did not score statistically significantly lower or higher than the QI Program aggregate on any measure.

Summary of Trend Analysis Results

The trend analysis revealed the following summary results:

- The 2020 QI Program aggregate scored statistically significantly lower than the 2018 scores in one measure, Getting Needed Care, Getting Care Quickly. Conversely, the 2020 QI Program aggregate scored statistically significantly higher than the 2018 scores in Coordination of Care.
- AlohaCare QI’s 2020 scores were not statistically significantly higher or lower than the 2018 scores in any measure.
- HMSA QI’s 2020 scores were statistically significantly lower than the 2018 scores in one measure, Customer Service
- Kaiser QI: This health plan’s 2020 scores were statistically significantly higher than the 2018 score on two measures, Rating of All Health Care and Coordination of Care.
- ‘Ohana QI’s 2020 score was not statistically significantly higher or lower than the 2018 score on any measure.
- UHCCP QI’s 2020 scores were statistically lower than the 2018 scores in one measure, Getting Care Quickly.

The QI Program’s scores were at or above the national averages on six measures: How Well Doctors Communicate, Coordination of Care, Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor and Rating of Specialist Seen Most Often.

Conversely, the QI Program's scores were below the national averages on three measures: Getting Needed Care, Getting Care Quickly and Customer Service.

The following observations from the key drivers of satisfaction analysis indicate areas of improvement in access and timeliness for the QI Program:

- Members' perceptions of not always easily getting the care, tests, or treatment they thought they needed.
- Members' perceptions of not easily obtaining appointments with specialists.
- Members' perceptions of not receiving care as soon as they needed it when they needed care right away.

The following observation from the key drivers of satisfaction analysis indicate areas of improvement in quality of care for the QI Program:

- Respondents reported that they are not always getting the information or help they needed from their health plan's customer service.
- Respondents' personal doctor not always seeming informed and up-to-date about the care they received from other doctors or health providers.
- Respondents reported that the forms from the health plan are often not easy to fill out.

I. Outcomes of any Focused Studies Conducted

See section XVIII.C, *Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State*.

J. Outcomes of any Reviews or Interviews Related to Measurement of any Disparities by Racial or Ethnic Groups

During this reporting period, there were no complaints or investigations regarding such disparities.

K. Annual Summary of Network Adequacy by Plan

MQD continues to review the Network Adequacy reports from all the health plans and communicate with the health plans that have issues on meeting the provider ratios.

Also, due to Hawaii's unique geography, there are select areas on the neighbor islands with shortages of behavioral health professionals and certain physical health specialists. This is not unique to the Medicaid line of business, but also prevalent in the commercial and Medicare lines. Recent telehealth policy changes at MQD will serve to increase provider access for members.

L. Summary of Outcomes of On-Site Reviews

1. EQRO

[Information on EQRO activities performed during the reporting period, is provided above in section XIV, *Quality Assurance and Monitoring Activity*.]

COVID-19 Impact

Due to guidelines outlined by President Trump's declaration of a national emergency in March 2020 in response to the coronavirus disease 2019 (COVID-19) outbreak in the United States and travel restrictions in the State of Hawaii, the on-site portion of the EQRO's review of the health plan's compliance with standards was changed to a virtual site review utilizing the Webex meeting platform.
Findings for the 2020 compliance review were determined from its:

- Desk review of the documents submitted by Health Plans to HSAG prior to the virtual site review.
- Credentialing, recredentialing, and organizational credentialing file reviews conducted prior to the virtual site review.
- Virtual site review activities that included reviewing additional documents and records, interviewing Health Plans' key administrative and program staff members, and viewing health plan presentations and system demonstrations.

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

Standards and Compliance Scores- AlohaCare QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	32	32	0	0	7	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**93**	**91**	**2**	**0**	**8**	**99%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- HMSA QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	10	1	0	0	95%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

	Total # of Elements: The total number of elements in each standard.
	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA.*
	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- Kaiser Foundation QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	4	6	0	0	70%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**88**	**10**	**0**	**3**	**95%**

	Total # of Elements: The total number of elements in each standard.

	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA.*
	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- ʻOhana QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	38	38	0	0	1	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**99**	**98**	**1**	**0**	**2**	**99%**

	Total # of Elements: The total number of elements in each standard.
	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA.*
	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- UHC QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	37	0	0	2	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

	Total # of Elements: The total number of elements in each standard.

	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.
	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- CCS

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	38	31	31	0	0	7	100%
IV	Quality Assessment and Performance Improvement	10	10	10	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**101**	**93**	**92**	**1**	**0**	**8**	**99%**

	Total # of Elements: The total number of elements in each standard.
	Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA.*
	Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

2. Financial

There is an ongoing joint investigation by MQD and the Medicaid Fraud Control Unit involving a Medicaid provider that is allegedly co-mingling patients' financial accounts, and failing to keep a detailed accounting record of all transactions.

Due to the COVID-19 Public Health Emergency, this investigation is still on-going.

3. Other Types of Reviews Conducted by the State or Contractor of the State

See section XVIII.C, *Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State*.

M. Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions

[Information on PIP activities performed during the reporting period, is provided above in section XIV.A.1, *Validation of Performance Improvement Projects (PIPs)*.]

The State contracted with HSAG as the MQD EQRO. One of the required functions of EQRO is to conduct the PIP activities. The following provides a summary of PIP results from the reporting period.

For each of the Performance Improvement Projects, health plans and CCS defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation. HSAG provided the following parameters for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

The following are summaries of this year's **Module 3** progress:

<u>1. AlohaCare</u>

Intervention Determination Summary for Improving Adolescent WellCare Visits PIP

Failure Modes	Potential Interventions
Member believes that he/she only needs to visit a provider when sick/injured.	• Provide the member educational material on adolescent well care (AWC) using technology (HealthCrowd), bilingual and interactive audio recordings, or texts. The message will describe who to schedule an AWC appointment with (primary care provider [PCP] or obstetrician/gynecologist [OB/GYN]) and why it is important. • Contact members who attended a sick visit but did not have an AWC visit within the measurement year and assist members with establishing care with their PCP. • Provide provider education on "max-packing" acute sick/injured visit with an AWC visit.
Member does not schedule AWC visit with assigned PCP.	• Incentivize lead care managers (LCMs) who have successfully assisted with scheduling an appointment with a parent/guardian or member, and for the member who has completed an AWC visit during the measurement year. • Incentivize providers, office staff, and community health workers who have successfully assisted with scheduling an appointment with a parent/guardian or member, and the member who has completed an AWC visit during the measurement year.

Provider schedules visit with member, but member fails to attend.	• LCM and providers will use 1:1 text messaging capability/outreach calls to assist with appointment reminders to members. • Incentivize members who have successfully completed an AWC visit during the measurement year (e.g., gift cards, coupons, movie tickets, monthly raffles).

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Behavioral health practitioner (BHP) noted on list may be unavailable during critical 7-day follow-up window.	• Collaborate with clinics, organizations, and/or individuals statewide who could provide face-to-face (F2F) or telehealth follow-up visits within 7 days after discharge for members hospitalized with mental illness or intentional self-harm. • Establish secure methods for providing telehealth, such as ZOOM. For example, ZOOM via Transition of Care Behavioral Health Care Coordinator (ToC BH CC) laptop at the time of ToC BH CC prearranged post-discharge visit, who could then contact the BHP for a telehealth visit.
Member may not prioritize contacting BHP from list.	• ToC BH CC and facility case managers take a more active role with the member in discharge planning during inpatient hospitalization, assisting the member in making an appointment with established BHPs (if discharge date is known), instead of providing the member a list of BHPs (current process). • Include in the inpatient discharge plan establishing with the member a definite date/time/place and method of contact within 24 hours of discharge to activate intervention #1 above (if discharge date is unknown).
Member may not call ToC BH CC at discharge.	• Include in the inpatient discharge plan ToC BH CC taking a more active role in establishing contact at discharge, such as confirming the member's address, telephone number, or other method of contact during the inpatient F2F visit (the current process is that the ToC BH CC gives the member a card containing his/her name and telephone number and instructs the member to contact the ToC BH CC at discharge, which puts the responsibility on the member to initiate contact). • Provide or assist in providing transportation for the member from the facility at discharge to the member's place of residence. This helps to ensure contact at discharge, as well as to confirm the member's contact information.

Member may not be aware of the importance of follow-up with a BHP within 7 days of discharge.	Include in the inpatient discharge plan providing education to the member regarding the importance of the 7-day follow-up visit with BHP, emphasizing that during the visit, the BHP can help the member address any concerns or need for further assistance, including but not limited to the following: • Assistance in obtaining medications as prescribed at the time of discharge, as well as assistance in meeting other current needs the member may have. • Assessment of the member's mental health status post-discharge. • Linking the member with case management or other services, as appropriate.

Conclusions

The validation findings suggest that AlohaCare successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. AlohaCare further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. AlohaCare has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

2. HMSA

Intervention Determination Summary for Adolescent Well-Care Visits PIP

Failure Modes	Potential Interventions
Member is not aware of the annual adolescent well-care visit benefit.	Targeted member education and incentives for completed adolescent wellcare visits.
Value of the visit is not understood by the parent, guardian, or adolescent.	Improve adolescent well-care visit messaging in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mailings.
Member is not aware of the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.
Member is not aware of how to access the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Members are scheduled for appointments greater than 7 days post-discharge.	• Educate facilities about the *FUH* measure and encourage them to set up an additional appointment within 7 days of discharge. • Assist members with obtaining telehealth appointments. • Perform transition of care activities with members within 2 business days of discharge.
Members are readmitted within 30 days of discharge.	• Assist members post-discharge through service coordination. • Connect members with community resources for crisis management.

Conclusions

The validation findings suggest that HMSA successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. HMSA further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. HMSA has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

3. Kaiser

Intervention Determination Summary for Adolescent Well-Care Visits PIP

Failure Modes	Potential Interventions
Staff do not know how to use the "Well-Child Visit" tool.	Educate staff on how to use the 'Well-Child Visit" tool to identify members who are due for a visit.
Member is not routinely placed on the wait list.	Use the "Well-Child Visit" tool to identify members and place them on the wait list for an appropriate due date.
Unable to contact member via a telephone call.	Use text messaging to confirm the appointment.
Demographic information is incorrect or outdated.	Educate staff to assure information is updated with each contact.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Member does not keep follow-up appointment.	Provide live reminder calls two days after discharge.
Unable to contact the member to reschedule a missed appointment or the member does not respond to messages/letter.	• Update member contact information prior to discharge. • Provide appointment information at discharge (i.e., "you will receive a reminder call two days after discharge about your follow-up appointment").
Member is not engaged or interested.	Provide education about the importance of a follow-up appointment during the live reminder call.

Conclusions

The validation findings suggest that KFHP successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. KFHP further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. KFHP has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

4. Ohana QI

Intervention Determination Summary for Improving Rates for Adolescent Well-Child Visits PIP

Failure Modes	Potential Interventions
Adolescent/parent/guardian cannot be reached by provider or health plan for assistance with scheduling an appointment.	Explore claims to see if members have any claims for providers not assigned to them. Reach out to those providers to see if the health plan can obtain the correct demographic information to contact members. Research other systems (e.g., Hawaii Health Information Exchange—Health eNet) to locate updated member demographic information.
Adolescent member and/or parents/guardians do not think they need a well-child visit and immunizations.	Patient care advocates (PCAs) and/or care gap coordinators (CGCs) emphasizing and educating on the importance of a well visit to members and their parents/guardians over the phone. Incentives for members (gift cards) to keep scheduled well-child visits (healthy rewards 2020).
Adolescent goes in for a sick visit, birth control, or a sport physical and not for a well-child visit.	Educating providers, members, and parents/guardians to do a well-child visit at the same time as a sick visit, OB/GYN visit, or physical.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge PIP

Failure Modes	Potential Interventions
Member does not have an adequate discharge plan before inpatient discharge.	Identify qualified BH provider who can focus on all the health plan members to briefly follow up with them post-discharge within 7 days. Conduct a short-term case management service to identify member needs the health plan can assist with such as housing, food assistance, etc.
CGC adds all members admitted for mental illness to the tracker but is unaware that the treating diagnosis could change during the course of the treatment.	Educate CGCs on the facility process and review the specifications of the measure to have them identify only the members who had a primary diagnosis of mental illness. Track the correct members for timely followup to be completed, within 7 days post-hospital discharge. Add the members to the tracker for follow-up. The CGC will mark the encounters with diagnoses that changed through the course of the treatment as changed diagnoses at discharge.
CGC does not see the importance of the process being completed in a timely manner.	Educate CGCs on the importance of completing member outreach soon after discharge to assure a timely follow-up appointment is scheduled. Add the process in the tracker to assure the CGC conducts timely member outreach and monitors the process.

Conclusions

The validation findings suggest that 'Ohana successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. 'Ohana further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. 'Ohana has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

5. UnitedHealthcare CP QI

Intervention Determination Summary for the Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center PIP

Failure Modes	Potential Interventions
Member/guardian does not initiate contact with Waianae Coast Comprehensive Health Center (WCCHC) to establish care.	UHC CP Member Services conducts telephonic outreach to members/guardians assigned to WCCHC who have not established care and are due for an AWC visit. Assist as needed and schedule a visit or update the member's PCP if care has been established elsewhere.

Member/guardian is unaware of the member's assignment to WCCHC.	UHC CP Member Services conducts telephonic outreach to members/guardians auto-assigned to WCCHC who have not established care and are due for an AWC visit. Inform auto-assigned PCP and assist as needed to schedule a visit with WCCHC or update the member's PCP if care has been established elsewhere.
Member/guardian's contact information is not current.	Collaborate with WCCHC and schools (if member is school-aged) on the data exchange process for member contact information. With updated contact information, UHC CP Member Services conducts outreach to members/guardians due for an AWC visit to assist as needed/schedule a visit.
Member/guardian does not feel the need to see WCCHC unless sick.	Develop and implement educational materials targeted toward adolescents about the importance of preventive care. Leverage social media to deliver message.
Member/guardian does not have transportation to the visit.	Collaborate with a community-based organization, like Hawaii Keiki, to expand reach of school-based clinics where members can complete AWC visits.

Intervention Determination Summary for the Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64 PIP

Failure Modes	Potential Interventions
Member lacks motivation to attend a follow-up appointment within seven days after discharge.	Modify the existing workflow to increase behavioral health field care advocate (BH FCA) face-to-face (FTF) visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is a no-show at the scheduled FTF follow-up visit with the BH FCA after discharge.	Modify the existing workflow to increase BH FCA FTF visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is unfamiliar with or lacks trust in the mental health practitioner (MHP).	If scheduling with previously seen MHPs is not possible, use BH FCA FTF visits to educate the member on the MHP and set up an introductory call between the member and MHP.
The follow-up appointment was scheduled with limited notice to the MHP.	Incentivize MHPs to see members within seven days after discharge.
There is a shortage of MHPs, especially with prescribing authority (i.e., psychiatrists).	Incentivize MHPs with prescribing authority to see members within seven days after discharge.

Conclusions

The validation findings suggest that UHC CP successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. UHC CP further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. UHC CP has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

6. Ohana CCS

Intervention Determination Summary for the Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge PIP

Failure Modes	Potential Interventions
Case manager (CM) does not contact the facility to arrange for the visit while the member is inpatient.	Care coordinator notifies CM liaison of the member's admission. CM liaison will track members from the time they admit as inpatient, up to two to three days post-discharge, and communicate with the assigned CM at the CBCM agency until the member is scheduled a follow-up appointment with a behavioral health (BH) provider within seven days of discharge.
CM does not arrange an in-person visit with the member during facility admission, prior to discharge.	Send a reminder notification to the CBCM agency if the visit during the member's inpatient admission is not captured in CellTrak (electronic health record [EHR]) within 24 hours. The reminder to the CBCM agency is to notify the agency that the visit had not been captured in CellTrak (if the visit had occurred). If the visit has not occurred and the member has not been discharged, it will be a reminder to visit the member.
CM is not trained and is unaware of the importance of meeting with the member prior to discharge and lacks supervision in initiating the next steps to meet with the member at the facility.	Work with the selected CBCM agencies and learn the process of new staff onboarding and training to identify the gaps in training. Then, work with these agencies to incorporate the CM to meet with the member at the facility while inpatient and plan for the member's care after discharge to ensure the follow-up appointment is made within seven days postdischarge. The health plan will monitor the *FUH* rates monthly.

Intervention Determination Summary for Follow-Up After Emergency Department Visit for Mental Illness PIP

Failure Modes	Potential Interventions
No real-time ED census data.	CMs at the health plan and IHS will receive real-time ED discharge notifications for members so they are aware that the members need followup appointments within seven days post-ED discharge. The CM liaison will receive the real-time census from a contracted vendor, Hawaii Health Information Exchange (HHIE)—Notify reporting system. CM liaisons assigned to the health plan—Acuity Level 5 team and IHS will send their assigned members' real-time ED visit notifications to the CMs.
Facility is busy and it is not a priority to notify the health plan of a member's visit to the ED.	Work with EDs across the State to provide the health plan's customer service number. The EDs should inform the health plan when a member visits the ED.
Member does not attend the scheduled visit on the date of the appointment due to transportation not having been set up to attend the visit.	Work with the CBCM agencies to identify the gaps in helping to arrange the follow-up visit for members and educate the agencies on how they can arrange transportation for members to attend the follow-up appointment.
Member does not see the value in attending the appointment.	Work with the CBCM agencies to identify that CMs are educating members on the importance of engaging in care to improve their health.
Member has other priorities.	Work with the CBCM agencies to ensure that CMs are working closely with members to identify issues and priorities. Assist members in eliminating barriers, put their health first as a priority, and engage in care.

Conclusions

The validation findings suggest that CCS successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. CCS further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. CCS has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

N. Outcomes of Performance Measure Monitoring

Summaries of the HEDIS 2020 Compliance Audit Final Report of Findings will be included for review in the 2020 External Quality Review Report of Results for the QUEST Integration Health Plans and the Community Care Services Program. This report was posted to the Med-QUEST website in March 2020.

Please see Attachment H for the Hawaii Calendar Year 2019 HEDIS 2020 Rate Spreadsheet.

O. Summary of Plan Financial Performance

The MLR experience for calendar year 2019 for each of the five MCOs is as follows:

- AlohaCare – 96.4%
- HMSA – 97.1%
- Kaiser – 94.7%
- Ohana – 100.7%
- UHC – 91.4%

XIX. Managed Care Organization and Program

A. Enrollment and Service Area Expansion of each MCO, PIHP, PAHP, and PCCM Entity

There were no service area expansions during the reporting period.

B. Modifications to, and Implementation of, MCO, PIHP, or PAHP Benefits Covered under the Contract with the State

The primary changes to the benefits were made due to the pandemic that required the State to abide by lockdown orders issued by the Governor. This necessitated looking at efforts the Division could implement to continue access to care by Medicaid recipients. The Division issued QUEST Integration memoranda that allowed services to be delivered using telehealth modalities. This included allowing telephonic-only services, clarification on FQHC services, coverage of EPSDT visits, and other evaluation and management codes not previously covered. The expansion of services are applicable only during the federal PHE.

C. Grievance, Appeals, and State Fair Hearings for the Managed Care Program

See section IV, *Grievances, Appeals & State Fair Hearings*, above.

D. Evaluation of MCO, PIHP, or PAHP Performance on Quality Measures

See sections XVIII.L, *Summary of Outcomes of On-Site Reviews* and XVIII.M, *Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions*.

E. Results of any Sanctions or Corrective Action Plans Imposed by the State or Other Formal or Informal Intervention with a Contracted MCO, PIHP, PAHP, or PCCM Entity to Improve Performance

There is an on-going corrective action plan with a provider, which is continuing due to the PHE.

F. Activities and Performance of the Beneficiary Support System

The MQD Beneficiary Support System is a combination of internal staff support along with an external contracted vendor. The Health Care Outreach Branch (HCOB) within MQD is the internal staff who identifies and assists hard to reach populations and those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers, justice-involved populations and those who are admitted to and discharged from public institutions. HCOB is present on all major islands, and also assists beneficiaries with submitting applications and enrollment into health plans for Medicaid and the Federal Health Insurance Marketplace.

For details, see section XI, *Outreach and Innovative Activities* above.

G. Other Factors in the Delivery of LTSS not otherwise addressed

There were no other factors impacting the delivery of LTSS during the reporting period. LTSS continued to be provided without interruption, and reassessments were extended by 6 months due to the PHE.

XX. Other

Final Rules

In continuous compliance of MCO Final Rules, Hawaii incorporated required provision in QUEST Integration Supplemental Changes #11 and the capitation rate for calendar year 2019. CMS approved on August 19, 2019. During the reporting period, MQD continued to work with CMS on the QI RFP Supplemental Changes #12 which includes more MCO Final Rules provisions and capitation rate for January to June 2020. CMS approved Supplemental Changes #12.

HOKU (Hawaii Online Kahu Utility)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD has moved forward with upgrading existing provider management software. A PMSU vendor was selected in FFY 2018 quarter three, and we received approval of this vendor contract in FFY 2019 quarter one. The Internal Verification & Validation (IVV) vendor was selected in FFY 2018 quarter four, to monitor the PMSU project. The initial go-live date of August 26, 2019 was postponed until March 2, 2020, to account for unforeseen complexities in business rules development and software coding and implementation. The go-live date was then postponed to April 13, 2020 to ensure thorough testing of the system. As we approached April 13, MQD and AHCCCS decided to postpone the go-live date due to the COVID-19 public health emergency (PHE). The official go-live date was August 3, 2020.

MQD named the PMSU project, Hawaii's Online Kahu Utility (HOKU). Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or pastor, one who looks after their flock. Med-QUEST providers are caretakers looking after and taking care of members.

MQD communicated memos QI-2006, QI-2006A and QI-2006B to the MCOs and providers that included information and updates on the go-live date, registration rollout in HOKU by waves, information about training materials and schedule and what an Application ID is.

MQD issued a request for proposal in 2019 to secure a vendor for our Provider Enrollment and Revalidation contract. MQD awarded the contract to Koan, with an effective contract date of January 1, 2020. With the Provider Enrollment and Revalidation contract, Koan is responsible with managing MQD's provider hotline, imaging (scanning) provider applications and assisting with screening and inputting provider enrollment and revalidation applications into the previous mainframe enrollment system, HPMMIS. Now that HOKU is live, Koan staff have been assisting with reviewing provider enrollment applications in HOKU and addressing provider questions related to enrollment and revalidation.

MQD hired a tech writer in Q1 of FFY 2020, however, that contractor resigned end of January 2020. MQD was then able to hire a new tech writer in June 2020 to continue the previous tech writer's work. The new tech writer worked on the provider training videos that will be available on MQD's HOKU webpage. There are training videos for each HOKU enrollment type (Group Biller, Individual Provider, Atypical Provider, Facility/Agency/Organization and Atypical Agency).

Due to the PHE, MQD faced a challenge where our provider enrollment applications were paper based only and majority of our staff began tele-working. Our clerical staff worked hard to scan our paper applications to a SharePoint site so that MQD and Koan staff could access them from home. MQD and Koan prioritized applications by working on new providers first. The reasoning for this is so that a provider ID number will be generated for new providers and they will be able to convert to the HOKU system and continue their re-registration.

MQD is continued to work in partnership with AHCCCS to identify and clean-up any conversion errors the defects that are detected in the system. MQD and AHCCCS met daily with CNSI to discuss and fix the system's defects. A goal for MQD and AHCCCS was to have very little to none priority 1 defects found.

As MQD approached Q4, we continued our efforts to process new paper applications, continued to work on HOKU conversion error clean-ups and prepare for HOKU's new launch date of August 3rd. MQD will worked on provider communications and updated the website. In preparation of the new launch date, MQD will hosted HOKU refresher courses for provider training session trainers (MCO staff) and MQD/Koan internal staff.

New Hawaii Medicaid providers were able to access once the system went live. The first two weeks were dedicated to our Wave 0 group, these were two organizations that we could work with directly as they inputted applications and we could identify any issues or recommended changes to HOKU. On August 17th, Wave 1 providers were able to access HOKU, which are our Group Billers. On September 14th, Wave 2 providers were able to access HOKU, which were all of our individual providers excluding MDs (Physicians).

The break-down for each wave, is the following.

HOKU Go-Live	
Wave 0	Hawaii Pacific Health and Kaiser Permanente Medical Group
Wave 1	Group billers (PT-01)
Wave 2	All individuals, excluding MDs (PT-C1, 27, 62, 51, BC, 34, 86, 09, 12, 16, 50, 07, D1, D2, D3, 31, 24, 21, 75, 48, 13, 69, 14, 18, 10, 11, 47, 19, 15)

In the first few months of HOKU's launch, MQD had a slow start on applications that were submitted by providers. However, as the applications began to roll in, we began to work on our process to review applications. We've also encounter issues along the way and worked with CNSI to log/track and resolve them. HI and AHCCCS met with CNSI daily to discuss our status and go over questions and issues.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) prepared to execute an Electronic Visit Verification (EVV) soft launch in early October. In the federal fiscal year (FFY) 2020, development, configuration, implementation, training and support of EVV was accomplished with the assistance of a statewide EVV vendor. MQD submitted the Good Faith Letter to CMS and received approval for implementation for the calendar year 2020.

FFY2020 continued with EVV requirements gathering, aligning EVV design with State policy, EVV systems and user interface development and configuration, and developing the training program with a statewide EVV vendor, as well as conducting statewide information forums throughout Hawai'i. Throughout FFY2020, MQD communicated progress to stakeholders via several modes of communication including email, face-to-face meetings, virtual meetings, virtual town halls, and EVV webpage updates.

MQD's future work will include, regular communications with stakeholders, working with the IV&V vendor, and working with the EVV vendor towards solution implementation and support.

FFY2020 summary:

In October, demonstrated the EVV solution to over 150 representatives from the Health Plans and Provider agencies. Reviewed the proposed HCPCS table for EVV services with the MCOs. Completed the Business Rules Workbook review with the EVV vendor. Many questions were raised because of the review. Three-quarters of the questions were addressed by the end of October. EVV vendor held the Outreach and Training Kick-off meeting for MQD and established reoccurring meetings to build the communications plan. Reviewed the EVV vendor device proposal with AHCCCS to ensure deliverable alignment.

In November, started engaging with the shared resources in Arizona to discuss the pre-payment visit validation and for data extraction. The EVV vendor held the Support Workstream kick-off to initiate the reoccurring meetings. Completed the MQD EVV Business Rules Workbook. Submitted the CMS Good Faith Effort request. The EVV vendor delivered final Technical Specification documents for MQD review. Delivered EVV content for Health Plans to include in their member quarterly newsletters.

In December, released the MQD EVV HCPCS service codes and modifiers memo and table to the Health Plans and providers. Hosted meetings with the MCOs, Provider Agencies, and DDD to review the HCPCS memo in early December. Reviewed CMS KPIs (key performance indicators) deliverables with the IV&V vendor. Attended multiple Technical Specification documentation reviews with the EVV Vendor.

In January, during the month of January 2020, the AZ and HI EVV Project Teams continued to focus on finalizing the Technical Specifications, participating in focused workstreams that address training, outreach, support, device management, and certification. Additionally, the team finalized the update to the Change Management Plan and facilitated their first Change Advisory Board (CAB). One of the critical tasks addressed in January was working towards an Integrated Master Schedule that includes Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The team worked to refine and sync the schedules between the states and Sandata to ensure all of the dependencies are coordinated and the goal is to baseline the schedule in February. Weekly Technical Review meetings were held with the MCOs and EVV vendor to ensure a smooth implementation. The Provider, Member, Authorization, Claims Validation, Alt EVV, OpenEVV-EVV, Data Warehouse Export, and Plan of Care EVV Technical

Specifications documents were approved. The EVV Training Plan was reviewed and approved with the EVV vendor.

In February, during the month of February 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification. A critical task that the teams continue to focus on is updating an Integrated Master Schedule (IMS) that includes both the Sandata and States tasks. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. Held final review of the Master Test Plan in preparation for approval. Continued engagement with the shared resources in Arizona to design the pre-payment visit validation and for data extraction.

In March, the EVV Project Team was actively involved in the Sandata Workstreams and reviewing applicable documentation from each workstream team. The current workstreams include Training, Outreach, Support, Device Management, Testing, and Certification. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. Finalized the EVV Device Guide document that will be distributed in the EVV Welcome Kit to Provider Agencies and Self-Directed Members. Incorporated final feedback into the Project Management Plan for review and approval.

In April, During the month of April 2020, the AZ and HI EVV Project Teams baselined the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. The baselined project schedule includes the Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The baselined project schedule adjusted the systems Go-Live from June to October with mandatory EVV use on December 30th, 2020. Received and reviewed the User Acceptance Test Cases from Sandata in preparation for testing. Completed the Staging Testing for the Provider and Member file formats & structure. Aligning with the Open Model approach, Alternate EVV vendor outreach materials were distributed to provider agencies and 3rd party vendors. Weekly Technical Review meetings were held with the MCOs and EVV vendor to ensure a smooth implementation.

In May, during the month of May 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification. Systems Integration Test cases given to HI MCOs in preparation for testing with Sandata. Addressed many inquiries by the MCOs regarding the SIT/UAT testing approach. MCOs continued to progress with Authorization file testing with Sandata. Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV baseline. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate.

In June, the EVV Project Team was actively involved in the Sandata Workstreams and reviewing applicable documentation from each workstream team. The current workstreams include Training, Outreach, Support, Device Management, Testing, and Certification. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. 100% of User Acceptance Test Cases were executed for Hawaii. 97% test cases passed with the remaining pending fixes from Sandata. Cycle 2 of User Acceptance Test was scheduled for August to address the testing of the outstanding issues. Most of the health plan test cases were completed with Sandata in June.

In July, during the month of July 2020, the AZ and HI EVV Project Teams continued to work the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. Demonstrated the EVV system to the provider agencies and MCOs. Meetings were hosted with the

MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV timeline and project. Confirmed and approved the change in training approach from face-to-face to virtual due to COVID-19. The MCOs completed the authorization test cases with Sandata. Aligning with the Open Model approach, Alternate EVV vendor testing with Sandata began.

In August, during the month of August 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification. Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV project. Coordinated and developed a standardized provider EVV communication with the MCOs that was sent to the EVV providers. Collaborated with the MCOs to align provider contract renewals with the mandated EVV service codes and modifiers. Finalized and approved the EVV training schedule. Met with the provider agencies to review the training schedule, authorization cutover and 3rd party EVV vendor requirements.

In September, hosted two virtual EVV town hall meetings open to the public. Med-QUEST completed the Provider and Member file uploads into the EVV system. The MCOs completed the authorization file uploads into the EVV system. MCO claims validation testing began that compares a claim from a provider agency against the EVV database. 100% of the UAT test cases passed and the UAT approval was granted. Prepared the evidence packets for the Operational Readiness Review with CMS/MITRE. Identified and mitigated a catastrophic service code mapping error through execution of extensive end-to-end testing.

Clinical Care Guidelines

The COVID-19 pandemic and resulting public health emergency (PHE) declared by the Department of Health and Human Services influenced much of the work for the Division during the 2020 FFY.

Telehealth utilization was encouraged through the issuance of multiple provider memoranda. Through the memos, guidance on the provision of services and coverage of allowable codes during the PHE have been issued. The provision of services through the use of telehealth modalities will continue into the new year and beyond. The health plans have begun to look at how they can continue to provide support to their providers and members to use telehealth to expand access to care for children, individuals living in remote areas, and elderly.

The pandemic also highlighted the need to further support Medicaid recipients, who are a nursing facility level of care, but residing and receiving home and community-based services. Planning and collaboration ensured that the recipients and their caregivers receiving special support with personal protective equipment that included distribution and support on the proper use and infection precautions. Special attention was also given to the care of residents in the residential group home who became infected with SARS-CoV-2.

Another effort by the Division included working with the long term care and Hawaii hospital association to engage stakeholders to update the criteria for the sub-acute level of care to address hospital waitlist issues and adjusting criteria to aid in the transfer of patients occupying acute care beds but at a lower level of care. This adjustment helps to open up acute care beds to address potential surges in cases of SARS CoV-2 patients needing inpatient care and to ensure recipients receive care at the appropriate setting.

XXI. MQD Contact

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QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-19					Nov-19					Dec-19				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	60,299	152,191	28,855	27,234	34,507	60,315	151,617	28,844	27,232	34,916	60,140	150,997	28,792	27,068	35,121
Duals	3,466	5,436	1,238	9,823	14,884	3,488	5,489	1,242	9,764	14,900	3,546	5,538	1,258	9,781	14,962
Total	**63,772**	**157,627**	**30,093**	**37,057**	**49,391**	**63,803**	**157,106**	**30,086**	**36,996**	**49,816**	**63,686**	**156,535**	**30,050**	**36,849**	**50,083**
# Network Providers															
PCPs	771	1,002	225	791	872	784	1,016	225	798	870	800	1,023	225	801	866
PCPs - (accepting new members)	638	784	216	577	655	653	795	212	581	645	674	801	213	584	633
Specialists	2,503	2,831	467	1,544	1,567	2,503	2,814	472	1,545	1,457	2,542	2,893	475	1,545	1,459
Specialists (accepting new members)	1,701	2,831	467	990	1,419	1,702	2,814	472	990	1,302	1,741	2,893	475	990	1,309
Behavioral Health	818	1,576	118	666	1,000	815	1,589	124	666	1,046	823	1,608	124	666	1,038
Behavioral Health (accepting new members)	727	1,576	118	626	959	725	1,589	124	626	1,007	736	1,608	124	626	1,001
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	47	37	16	38	34	47	37	17	38	33	40	37	17	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	565	612	160	1,031	1,219	561	612	161	1,033	1,351	567	618	137	1,036	1,210
HCBS Providers (except residential settings and LTSS facilities)	75	155	68	91	77	74	156	70	91	77	72	155	70	91	73
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,837	2,322	130	1,774	1,777	1,843	2,323	132	1,776	1,603	1,857	2,361	134	1,776	1,731
Total # of providers	**6,641**	**8,562**	**1,196**	**5,959**	**6,569**	**6,652**	**8,574**	**1,213**	**5,971**	**6,460**	**6,726**	**8,722**	**1,194**	**5,977**	**6,434**
Call Center															
# Member Calls	5,261	7,609	556	8,374	4,646	3,964	5,744	848	7,001	4,201	3,939	6,143	615	6,767	3,954
Avg. time until phone answered	0:00:30	0:00:16	0:00:08	0:00:42	0:00:13	0:00:25	0:00:13	0:00:11	0:00:22	0:00:22	0:00:07	0:00:07	0:00:14	0:00:28	0:00:18
Avg. time on phone with member	0:05:09	0:07:09	0:05:10	0:07:55	0:07:07	0:06:21	0:07:19	0:04:49	0:07:36	0:07:12	0:06:07	0:06:38	0:05:40	0:08:06	0:06:57
% of member calls abandoned (member hung up)	3.6%	1.6%	0%	5.0%	0.8%	3.00%	1.9%	1%	4.9%	1.9%	0.69%	1.4%	3%	4.3%	1.4%
# Provider Calls	9,552	6,040	64	3,915	3,293	7,410	4,924	70	2,968	2,710	7,658	5,064	75	3,105	3,184
Avg. time until phone answered	0:00:31	0:00:26	0:00:11	0:01:17	0:00:04	0:00:32	0:00:19	0:00:06	0:00:27	0:00:03	0:00:19	0:00:11	0:00:23	0:00:29	0:00:04
Avg. time on phone with provider	0:05:12	0:07:45	0:03:15	0:10:35	0:07:04	0:05:54	0:08:00	0:05:20	0:11:59	0:07:26	0:06:01	0:07:32	0:05:27	0:12:14	0:06:51
% of provider calls abandoned (provider hung up)	3.7%	1.7%	0%	7.4%	0.6%	3.04%	2.1%	0%	3.1%	0.3%	1.38%	0.9%	5%	2.8%	0.4%
Medical Claims- Electronic															
# Submitted, not able to get into system	2,960	2,187	-	3,267	2,942	2,159	1,699	-	2,903	3,578	2,661	7,867	-	3,065	7,217
# Received	55,520	163,787	26,821	61,508	78,549	50,822	145,530	28,194	58,084	79,115	51,281	149,416	26,737	54,280	82,063
# Paid	48,605	167,387	25,923	49,428	69,645	42,409	132,257	27,014	54,340	73,671	54,931	126,978	25,158	48,262	73,541
# In Process	9,297	31,962	73	16,121	2,425	15,767	35,925	382	10,889	56,322	8,932	49,329	784	10,756	21,870
# Denied	2,684	11,988	825	7,326	7,241	2,220	9,310	798	8,450	7,179	2,831	9,034	795	6,227	8,162
Avg time for processing claim in days	5	8	1	9	7	6	9	1	8	8	6	9	1	11	7
% of electronic claims processed in 30 days	99%	99%	100%	99.6%	99.5%	98.6%	99%	99.99%	99%	99.7%	98.0%	98%	99.5%	98.4%	99.6%
% of electronic claims processed in 90 days	99.8%	99.9%	100%	99.9%	100%	99.8%	100.0%	99.99%	99.9%	100%	99.9%	100%	100.0%	99.3%	99.98%
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	281	956	0	215	516	276	1,074	1	161	845	313	1,238	0	176	625
# Received	19,857	17,779	57	4,744	7,187	9,771	16,026	70	4,664	6,679	13,445	15,608	21	5,733	8,273
# Paid	17,306	15,908	45	4,786	5,930	12,506	14,134	60	5,111	5,740	16,326	12,765	11	3,876	7,071
# In Process	9,344	8,506	0	2,180	436	4,914	7,992	3	860	7,141	4,129	8,916	5	1,642	3,480
# Denied	2,251	2,827	12	1,493	1,252	1,677	2,406	7	1,720	1,122	2,541	1,919	5	1,064	1,399
Avg time for processing claim in days	16	16	6	17	8	14	15	7	10	10	19	15	5	11	9
% of electronic claims processed in 30 days	95.8%	95.7%	100%	99.7%	99.8%	96.7%	95.1%	98.5%	98.7%	99.2%	94.4%	95.5%	100%	99.1%	99.2%
% of electronic claims processed in 90 days	99.5%	99.8%	100%	99.9%	100%	99.6%	99.8%	100%	99.4%	100%	98.7%	99.5%	100%	100.0%	99.9%
Prior Authorization (PA)- Electronic															
# Received	161	2,294	612	114	2,710	120	1,919	534	100	2,206	128	1,718	585	106	2,344
# In Process	36	382	15	108	0	22	339	19	98	0	21	146	32	97	0
# Approved	119	2,091	576	106	2,217	92	1,729	500	98	1,804	102	1,690	524	90	1,910
# Denied	25	238	18	4	268	33	233	15	6	236	17	224	29	8	249
Avg time for PA in days	1	5	3	1	2	1	5	2	1	0	1	4	3	1	2
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,747	553	0	1,900	86	1,534	466	0	1,526	54	1,377	638	0	1,744	79
# In Process	327	52	0	1,790	0	326	62	0	1,441	0	209	87	0	1,610	0
# Approved	1,364	508	0	1,863	69	1,162	422	0	1,512	45	1,227	559	0	1,659	72
# Denied	207	58	0	38	8	151	34	0	29	7	152	54	0	27	4
Avg time for PA in days	2	2	0	2	3	2	2	0	1	2	2	2	0	2	2
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	2,568	5,676	455	6,922	9,389	3,078	5,373	391	6,162	8,493	3,052	5,450	467	6,058	8,692
Air (by segment)	1,624	1,212	262	623	915	1,361	1,724	212	542	890	1,340	1,778	242	527	763
Public Transportation Pass (bus pass & handivan coupons)	1,406	1,062	423	2,146	786	1,270	1,152	490	2,026	1,964	1,192	1,292	705	2,046	1,152
# Member Grievances															
# Received	20	12	14	33	35	16	11	7	30	37	13	8	12	31	26
# Resolved	24	14	18	14	35	18	11	9	20	35	13	11	11	16	34
# Outstanding	11	9	9	15	9	9	9	7	10	11	9	6	8	15	3

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-19					Nov-19					Dec-19				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Provider Grievances															
# Received	82	0	0	0	0	80	1	0	1	0	100	0	0	3	0
# Resolved	7	0	0	0	0	0	1	0	0	0	2	0	0	1	0
# Outstanding	236	0	0	0	0	316	0	0	1	0	414	0	0	2	0
# Member Appeals															
# Received	5	78	2	7	17	6	66	0	7	17	9	67	0	6	12
# Resolved	5	77	0	7	9	6	68	2	9	22	6	72	0	5	14
# Outstanding	4	34	2	7	20	4	32	0	5	15	7	27	0	6	13
# Provider Appeals															
# Received	24	2	0	47	153	27	2	0	84	90	15	11	0	91	139
# Resolved	2	4	0	62	155	0	2	0	32	66	1	5	0	15	135
# Outstanding	84	18	0	15	17	113	18	0	67	41	125	24	0	143	45
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	83	88	5	127	200	74	85	4	133	170					
Inpatient Acute Days * (A) - per 1,000	474	259	25	551	732	405	254	26	650	600					
Readmissions within 30 days* (A)	47	178	28	45	47	41	158	35	67	37					
ED Visits * (C) - per 1,000**	617	480	27	775	642	618	478	28	702	642					
# Prescriptions (C) - per 1,000	9,186	10,417	658	13,544	14,661	8,523	9,674	591	12,287	13,336					
Waitlisted Days * (A) - per 1,000	53	0	4	52	192	34	0	4	81	145					
NF Admits * (A)	43	17	1	9	18	28	13	2	1	23					
# Members in NF (non-Medicare paid days) (C)**	222	240	55	773	865	229	234	63	713	871					
# Members in HCBS **(C)- note: member can be included in more than one category listed below	220	469	224	2,155	1,361	179	471	225	2,076	1,325					
# Members in Residential Setting **(C)	129	110	132	539	883	120	114	138	499	867					
# Members in Self-Direction **(C)	77	181	28	834	285	80	178	32	821	272					
# Members receiving other HCBS **(C)	93	359	196	1321	192	60	357	193	1255	185					
# Members in At-Risk ** (C)	455	480	109	902	980	473	503	111	892	1,003					
# Members in Self-Direction **(C)	265	204	34	461	600	274	227	34	457	591					
# Members receiving other HCBS **(C)	190	462	75	470	380	199	487	77	457	412					

(* non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility

Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.

PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

CMS 1500- physicians, HCBS providers eg.case management agencies, CCFFH/EARCH/ALF, home care agencies , 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.

QUEST Integration Health Plan Demographic Information by Island as of: 12/31/2019

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	458	83	15	12	63	71	98	800
PCPs - (accepting new members)	**381**	**71**	**12**	**10**	**55**	**58**	**87**	**674**
Specialists*	1,887	210	25	0	172	71	177	2,542
members)	**1,291**	**139**	**11**	**0**	**115**	**49**	**136**	**1,741**
Behavioral Health*	516	108	11	2	47	76	63	823
Behavioral Health (accepting new members)	**449**	**100**	**11**	**2**	**45**	**72**	**57**	**736**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	22	3	0	1	5	5	4	40
Residential Setting (CCFFH, E-ARCH, and ALF)	464	27	1	0	9	50	16	567
HCBS Providers (except residential settings and LTSS facilities)	34	11	3	3	6	10	5	72
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,204	220	24	12	136	125	136	1,857
Totals	**4,597**	**664**	**80**	**31**	**441**	**409**	**504**	**6,726**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	35,827	8,064	2,195	440	5,161	6,205	5,794	**63,686**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	78	97	146	37	82	87	59	80

Note: RFP requirement is 300 members for every PCP

HMSA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	634	89	14	14	64	97	111	1,023
PCPs - (accepting new members)	**479**	**67**	**12**	**9**	**49**	**84**	**101**	**801**
Specialists*	1,781	272	64	28	175	271	302	2,893
members)	**1,781**	**272**	**64**	**28**	**175**	**271**	**302**	**2,893**
Behavioral Health*	1,005	187	9	6	87	180	134	1,608
Behavioral Health (accepting new members)	**1,005**	**187**	**9**	**6**	**87**	**180**	**134**	**1,608**
Hospitals	14	2	1	1	3	1	5	27
LTSS Facilities (Hosp./NF)	25	2	1		3	5	1	37
Residential Setting (CCFFH, E-ARCH, and ALF)	490	28	1		11	65	23	618
HCBS Providers (except residential settings and LTSS facilities)	70	20	9	6	16	24	10	155
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,545	245	28	17	165	153	208	2,361
Totals								**8,722**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	91,228	10,900	858	142	10,299	26,088	17,020	**156,535**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	144	122	61	10	161	269	153	153

Note: RFP requirement is 300 members for every PCP

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	164	61						225
PCPs - (accepting new members)	**160**	**53**						**213**
Specialists*	384	91						475
members)	**384**	**91**						**475**
Behavioral Health*	103	21						124
Behavioral Health (accepting new members)	**103**	**21**						**124**
Hospitals	10	2						12
LTSS Facilities (Hosp./NF)	16	1						17
Residential Setting (CCFFH, E-ARCH, and ALF)	124	13						137
HCBS Providers (except residential settings and LTSS facilities)	58	12						70
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	100	34						134
Totals	**959**	**235**	**0**	**0**	**0**	**0**	**0**	**1,194**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	19,853	10,197						**30,050**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	121	167	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	134

Note: RFP requirement is 300 members for every PCP

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	549	50	9	10	72	66	45	801
PCPs - (accepting new members)	**408**	**33**	**9**	**10**	**58**	**31**	**35**	**584**
Specialists*	1,164	107	13	4	113	75	69	1,545
members)	**705**	**88**	**13**	**4**	**53**	**66**	**61**	**990**
Behavioral Health*	463	49	4	0	34	72	44	666
Behavioral Health (accepting new members)	**447**	**34**	**3**	**0**	**34**	**68**	**40**	**626**
Hospitals	11	2	1	1	3	1	5	24
LTSS Facilities (Hosp./NF)	23	3	1	1	5	2	3	38
Residential Setting (CCFFH, E-ARCH, and ALF)	870	41	0	0	18	83	24	1,036
HCBS Providers (except residential settings and LTSS facilities)	51	8	2	0	4	20	6	91
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,117	180	15	6	131	171	156	1,776
Totals	**4,248**	**440**	**45**	**22**	**380**	**490**	**352**	**5,977**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	23,355	3,757	421	97	1,873	4,568	2,778	**36,849**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	43	75	47	10	26	69	62	46

Note: RFP requirement is 300 members for every PCP

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	550	65	8	5	57	69	50	804
PCPs - (accepting new members)	**410**	**39**	**7**	**4**	**50**	**40**	**36**	**586**
Specialists*	1,140	135	57	6	107	131	118	1,694
members)	**1,014**	**122**	**44**	**6**	**98**	**114**	**107**	**1,505**
Behavioral Health*	759	236	62	63	162	235	199	1,716
Behavioral Health (accepting new members)	**732**	**233**	**62**	**63**	**158**	**231**	**193**	**1,672**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	25	2	0	0	3	4	1	35
Residential Setting (CCFFH, E-ARCH, and ALF)	992	55	2	0	24	114	23	1,210
HCBS Providers (except residential settings and LTSS facilities)	57	11	1	0	8	21	5	103
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,260	198	19	12	124	159	141	1,913
Totals	**4,793**	**705**	**150**	**87**	**488**	**737**	**540**	**7,500**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	33,289	4,128	262	89	2,569	6,462	3,284	**50,083**
								0

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	61	64	33	18	45	94	66	62

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls

as of: 12/31/2019

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	42	2	0	0	3	3	3	**53**
Network (provider look up, access)	54	2	0	0	5	8	6	**75**
Primary Care Physician Assignment or Change	146	21	8	1	12	13	8	**209**
NEMT (inquiry, scheduling) -*monthly report*	244	42	17	4	15	53	28	**403**
Authorization/Notification (prior auth status)	273	54	9	5	24	50	18	**433**
Eligibility (general plan eligiblity, change request)	272	22	3	1	13	23	14	**348**
Benefits (coverage inquiry)	45	7	1	0	3	10	8	**74**
Enrollment (ID card request, update member information)	11	2	1	0	0	3	1	**18**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	148	15	0	0	2	14	5	**184**
Billing/Payment/Claims	404	103	3	1	17	18	12	**558**
Appeals	3	0	0	0	0	0	0	**3**
Complaints and Grievances	0	0	0	0	0	0	0	**0**
Other	129	16	2	0	9	14	2	**172**
Totals	**1,771**	**286**	**44**	**12**	**103**	**209**	**105**	**2,530**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	29	3	0	0	5	3	4	**44**
Network (provider look up, access)	49	6	0	0	3	9	13	**80**
Primary Care Physician Assignment or Change	1,143	125	23	1	157	239	251	**1,939**
NEMT (inquiry, scheduling) -*monthly report*	4	0	0	0	0	4	0	**8**
Authorization/Notification (prior auth status)	25	6	0	0	7	7	9	**54**
Eligibility (general plan eligiblity, change request)	472	50	4	1	38	80	47	**692**
Benefits (coverage inquiry)	107	21	0	0	24	26	30	**208**
Enrollment (ID card request, update member information)	477	76	5	0	43	120	96	**817**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	31	4	0	0	7	12	6	**60**
Billing/Payment/Claims	123	44	0	0	13	31	24	**235**
Appeals	0	0	0	0	0	0	0	**0**
Complaints and Grievances	5	2	0	0	0	4	0	**11**
Other	226	56	1	0	38	68	68	**457**
Totals	**2,691**	**393**	**33**	**2**	**335**	**603**	**548**	**4,605**

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KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	0	2						**2**
Network (provider look up, access)	64	18						**82**
Primary Care Physician Assignment or Change	6	5						**11**
NEMT (inquiry, scheduling) -*monthly report*	24	0						**24**
Authorization/Notification (prior auth status)	0	0						**0**
Eligibility (general plan eligiblity, change request)	180	36						**216**
Benefits (coverage inquiry)	144	27						**171**
Enrollment (ID card request, update member information)	39	9						**48**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	38	10						**48**
Appeals	0	0						**0**
Complaints and Grievances	1	0						**1**
Other	67	20						**87**
Totals	**563**	**127**	**0**	**0**	**0**	**0**	**0**	**690**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	324	64	5	0	9	88	25	**515**
Network (provider look up, access)	32	8	0	0	3	2	1	**46**
Primary Care Physician Assignment or Change	112	13	4	0	1	18	12	**160**
NEMT (inquiry, scheduling) -*monthly report*	2,101	403	70	30	4	12	54	**2,674**
Authorization/Notification (prior auth status)	14	31	10	0	5	27	15	**102**
Eligibility (general plan eligiblity, change request)	74	13	0	0	6	17	6	**116**
Benefits (coverage inquiry)	168	31	4	0	13	46	22	**284**
Enrollment (ID card request, update member information)	261	26	11	0	15	61	21	**395**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	94	13	8	1	3	15	7	**141**
Billing/Payment/Claims	25	7	0	0	0	5	2	**39**
Appeals	17	8	0	0	1	6	2	**34**
Complaints and Grievances	17	1	0	0	0	7	2	**27**
Other	921	155	18	0	50	206	102	**1,452**
Totals	**4,160**	**773**	**130**	**31**	**110**	**510**	**271**	**5,985**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	146	22	1	0	9	32	13	**223**
Network (provider look up, access)	149	33	2	0	18	41	10	**253**
Primary Care Physician Assignment or Change	468	73	8	0	42	107	55	**753**
NEMT (inquiry, scheduling) -*monthly repor* t	47	25	2	1	6	41	11	**133**
Authorization/Notification (prior auth status)	33	30	1	0	9	63	8	**144**
Eligibility (general plan eligiblity, change request)	344	63	1	1	31	91	39	**570**
Benefits (coverage inquiry)	597	90	7	1	52	132	47	**926**
Enrollment (ID card request, update member information)	148	21	3	0	10	36	11	**229**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	97	15	0	0	3	24	6	**145**
Billing/Payment/Claims	1	0	0	0	0	0	0	**1**
Appeals	3	3	0	0	0	2	2	**10**
Complaints and Grievances	5	2	0	0	0	0	2	**9**
Other	213	35	0	0	13	46	16	**323**
Totals	**2,251**	**412**	**25**	**3**	**193**	**615**	**220**	**3,719**

Health plan shall highlight changes made for the previous month(s)	
# Members	Description of Information to Include
Medicaid	Number of members receiving QI benefit package who do not have Medicare primary
Duals	Number of members receiving dual benefits
Total	Total number of members
# Network Providers	**Providers count on the "Dashboard" sheet should be un-duplicated. The providers counts on the "HP Demographics by Island" sheet may be duplicated when an individual provider serves multiple islands. Providers such as pharmacy services may be counted based upon number of locations. Non-Hawaii based network providers shall be excluded from all counts.**
PCPs	PCP count includes PCPs in the clinics. Utilize the definition provided on the Report Tool
PCPs - (accepting new members)	Number of PCPs (includes PCPs in clinics) accepting new members
Specialists	All specialists as defined in Section 40.220
Specialists (accepting new members)	Number of Specialists accepting new members
Behavioral Health	All behavioral health providers as defined in Section 40.220
Behavioral Health (accepting new members)	Number of Behavioral Health providers accepting new members
Hospitals	All hospitals
LTSS Facilities (Hosp./NF)	All facilities that have residents receiving LTSS (both hospital-based and free-standing nursing facilities)
Residential Setting (CCFFH, E-ARCH, and ALF)	All residential settings (CCFFH, E-ARCH, and ALF)
HCBS Providers (except residential settings and LTSS facilities)	All other HCBS providers as defined in Section 40.220 excluding those that are residential settings of LTSS facilities
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	All ancillary providers to include pharmacies, laboratories, therapists, hospice, home health agencies.
Total # of providers	Total of all providers listed
	Note: all providers in the QI network should be included. There should be no duplication of provider counts per category. If type is not listed, add provider type to the "Ancillary & Other" section.
Call Center	
# Member Calls	# of calls received from members
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with member	Average time on the phone with member in minutes and seconds
% of member calls abandoned (member hung up)	Percent of member calls abandoned
# Provider Calls	# of calls received from providers
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with provider	Average time on the phone with provider in minutes and seconds
% of provider calls abandoned (provider hung up)	Percent of provider calls abandoned
Medical Claims- Electronic	**Note: (1) A " Processed claim" is a QI claim (not based on # of items/lines in the claim) that "PAID" or "DENIED" in the reporting period. Health plan shall determine how a claim is considered "PAID" or "DENIED". (2) When a single claim that has multiple RECEIVED/PAID/DENIED dates, health plan should use the LAST DATE that the final "PAID" or "DENIED" item/line is made for the 30/90 days calculation because this will be a "completely" processed claim.**
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of electronic claims processed in 30 days
% of claims processed in 90 days	% of electronic claims processed in 90 days
(month to date)	
Medical Claims- Paper	
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month

Measure	Description
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of paper claims processed in 30 days
% of claims processed in 90 days	% of paper claims processed in 90 days
(month-to-date)	
Prior Authorization (PA)- Electronic	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month to date)	
Prior Authorization (PA)- Paper and Telephone	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month-to-date)	
# Non-Emergency Transports	
Ground (# of round trips)	# of ground trips for non-emergency transports. A roundtrip is counted as one (i.e., to MD appointment and home is one (1) trip not two (2) trips)
Air (by segment)	# of air trips (by segment) for non-emergency transports i.e. fly from Maui to HNL and back count as 2 segments
Public Transportation Pass (bus pass & handivan coupons)	# of bus passes or handivan coupons issued
# Member Grievances	
# Received	# of member grievances received in the month
# Resolved	# of member grievances resolved in the month
# Outstanding	# of outstanding member grievances at the end of the month Note: The number of member grievances outstanding in this month is the number of member grievances outstanding in the prior month plus the number of member grievances received in this month minus the number of member grievances resolved in this month.
# Provider Grievances	
# Received	# of provider grievances received in the month
# Resolved	# of provider grievances resolved in the month
# Outstanding	# of outstanding provider grievances at the end of the month Note: The number of provider grievances outstanding in this month is the number of provider grievances outstanding in the prior month plus the number of provider grievances received in this month minus the number of provider grievances resolved in this month.
# Member Appeals	
# Received	# of member appeals received in the month
# Resolved	# of member appeals resolved in the month
# Outstanding	# of outstanding member appeals at the end of the month Note: The number of member appeals outstanding in this month is the number of member appeals outstanding in the prior month plus the number of member appeals received in this month minus the number of member appeals resolved in this month.
# Provider Appeals	
# Received	# of provider appeals received in the month
# Resolved	# of provider appeals resolved in the month
# Outstanding	# of outstanding provider appeals at the end of the month Note: The number of provider appeals outstanding in this month is the number of provider appeals outstanding in the prior month plus the number of provider appeals received in this month minus the number of provider appeals resolved in this month.
Utilization - based on Auth (A) or Claims (C)	
Inpatient Acute Admits * (A) - per 1,000	# of inpatient acute admits (based on authorizations) in the month per 1,000 members

Measure	Definition
Inpatient Acute Days * (A) - per 1,000	# of inpatient acute days (based on authorizations) in the month per 1,000 members
Readmissions within 30 days* (A)	# of readmissions within thirty (30) days in the month based upon authorizations
ED Visits* (C) - per 1,000**	# of ER visits in the previous month (based upon claims) per 1,000. For example, if reporting is on September 15th for August, provide data for July ER visits.
# Prescriptions (C) - per 1,000	# of prescriptions in the month (based upon claims) per 1,000 members
Waitlisted Days* (A) - per 1,000	# of waitlisted days in the month (based upon authorizations) per 1,000 members
NF Admits * (A)	Authorized Non-Medicare nursing facility admissions
# Members in NF (non-Medicare paid days)**(C)	Non-Medicare paid days (claims based)
# Members in HCBS **(C)	# of members in HCBS (excluldes members in at-risk) in the month (based upon claims). Member can be included in more than one category listed below. Note: (1) The listing of HCPCS codes listed on the LTSS Report (Tab D. Auth by Service Code) shall be used to determine those HCPCS codes categorized as 'HCBS' (2) The # of members in HCBS (C) will be based solely on paid claims during the reporting period. This determination will be made irrespective of the member's "1148" status/facility code (e.g. "299")
# Members in Residential Setting **(C)	# of HCBS members in Residential Setting (based upon claims). Note: Based solely on paid claims against HCPCS S5140, T2033 and T2031.
# Members in Self-Direction **(C)	# of HCBS members in Self-Direction (based upon claims)
# Members receiving other HCBS **(C)	# of HCBS members receiving other HCBS servcies (based upon claims) as defined in Section 40.740.3
# Members in At-risk**(C)	# of members in At-risk in the month (based upon claims). Note: The population of At-risk members will be based on a member having an active "at-risk" coded 1147 (i.e. Level of Care Approval Status = 11). Only those with paid claims against HCBS codes noted above shall be included.
# Members in Self-Direction ** (C)	# of At-risk members in Self-Direction in the month (based upon claims)
# Members receiving other HCBS** (C)	# of At-risk members receiving other HCBS services (based upon claims)
	Note: Non-Medicare is for acute, ED, and prescriptions. Health plans should report on acute waitlisted, Medicaid primary NF, and all HCBS (even if these individuals are duals).

(*Non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility
Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.
PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jan-20					Feb-20					Mar-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	59.415	152.062	29.542	26.328	35.864	59.226	151.528	29.465	26.159	33.909	59.489	151.640	29.420	26.242	33.705
Duals	3.437	5.499	1.287	9.473	14.946	3.461	5.536	1.299	9.386	15.071	3.512	5.638	1.298	9.374	15.003
Total	62.852	157.561	30.829	35.801	50.810	62.687	157.064	30.764	35.545	48.980	63.001	157.278	30.718	35.616	48.708
# Network Providers															
PCPs	804	1.023	226	795	871	799	1.025	239	795	870	815	1.031	241	795	882
PCPs - (accepting new members)	676	798	213	578	633	671	805	227	578	634	688	813	228	578	643
Specialists	2.563	2.947	475	1.545	1.493	2.612	2.991	474	1.545	1.492	2.617	2.979	474	1.547	1.501
Specialists (accepting new members)	1.764	2.947	475	990	1.344	1.816	2.991	474	990	1.345	1.827	2.979	474	992	1.354
Behavioral Health	827	1.631	124	666	1.033	847	1.641	118	666	1.037	855	1.654	116	667	1.040
Behavioral Health (accepting new members)	739	1.631	124	626	998	757	1.641	118	626	1.001	762	1.654	116	627	1.004
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	47	37	17	38	34	48	37	16	38	34	48	37	16	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	569	626	139	1.036	1.194	574	627	109	1.036	1.197	588	628	123	1.040	1.196
HCBS Providers (except residential settings and LTSS facilities)	72	157	70	91	59	72	157	65	91	60	72	158	72	91	60
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1.862	2.442	132	1.776	1.780	1.884	2.437	122	1.776	1.773	1.880	2.445	121	1.779	1.779
Total # of providers	**6.769**	**8.890**	**1.195**	**5.971**	**6.487**	**6.861**	**8.942**	**1.156**	**5.971**	**6.486**	**6.900**	**8.959**	**1.175**	**5.981**	**6.515**
Call Center															
# Member Calls	4.493	8.297	848	7.934	4.714	3.973	6.666	408	6.449	3.925	3.865	6.346	326	6.127	3.688
Avg. time until phone answered	0:00:08	0:00:08	0:00:10	0:00:23	0:00:22	0:00:09	0:00:16	0:00:14	0:00:21	0:00:16	0:00:08	0:00:18	0:00:09	0:00:56	0:00:15
Avg. time on phone with member	0:05:57	0:06:25	0:04:41	0:08:03	0:06:55	0:05:59	0:06:21	0:04:59	0:08:52	0:07:01	0:05:56	0:05:46	0:05:45	0:08:21	0:06:45
% of member calls abandoned (member hung up)	0.6%	0.1%	2.7%	3.0%	1.4%	1.0%	1.2%	2.0%	2.9%	0.9%	0.5%	1.6%	1.0%	2.6%	1.0%
# Provider Calls	8.215	5.649	70	3.509	3.618	7.284	5.314	68	3.177	3.004	7.205	5.380	73	2.827	2.854
Avg. time until phone answered	0:00:22	0:00:16	0:00:21	0:00:14	0:00:01	0:00:25	0:00:21	0:00:13	0:00:27	0:00:01	0:00:18	0:00:22	0:00:04	0:00:08	0:00:02
Avg. time on phone with provider	0:05:36	0:07:08	0:03:52	0:11:57	0:06:40	0:05:43	0:07:29	0:03:49	0:11:42	0:06:59	0:05:52	0:07:40	0:03:57	0:11:22	0:07:18
% of provider calls abandoned (provider hung up)	1.30%	1.45%	0.00%	2.56%	0.1%	1.66%	1.47%	0.00%	3.46%	0.1%	1.00%	1.95%	4.00%	1.70%	0.1%
Medical Claims- Electronic															
# Submitted, not able to get into system	2889	3.235	0	2.991	5.629	2171	1239	0	2.796	5.193	2760	1319	0	2.787	5.076
# Received	52.488	156.082	31.038	55.626	82.596	51.264	149.417	33.223	53.564	77.981	54.799	151.707	32.429	53.528	84.449
# Paid	44.272	152.582	28.333	47.000	78.683	50.835	133.613	32.055	46.222	71.276	54.236	137.618	29.598	44.876	77.776
# In Process	15.001	40.578	1.843	13.365	14.679	12.447	45.603	430	6.159	18.855	9.041	48.470	818	2.746	20.138
# Denied	2.235	11.974	862	5.832	8.763	3.392	10.741	738	9.350	7.395	3.511	11.171	2.013	9.631	8.637
Avg time for processing claim in days	6	10	1	9	10	8	9	1	6	7	5	9	1	6	8
% of electronic claims processed in 30 days	95.6%	97.3%	99.98%	98.1%	99.3%	94.7%	98%	99.97%	99%	98.9%	98.8%	98%	99.97%	100%	96.3%
% of electronic claims processed in 90 days	99.9%	99.8%	99.99%	99.86%	99.96%	94.9%	100%	99.98%	100%	99.98%	99.8%	100%	100%	100%	100%
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	266	902	0	236	690	309	724	3	115	718	530	1.239	5	94	792
# Received	11.893	16.421	28	5.036	8.202	10.485	16.186	24	5.168	7.151	15.544	15.958	33	5.167	7.310
# Paid	13.521	14.652	16	3.235	6.719	14.020	12.478	8	4.012	6.113	19.856	13.289	22	2.841	6.934
# In Process	5.174	8.464	1	1.847	3.302	6.796	9.993	12	611	3.859	5.814	10.181	0	266	2.981
# Denied	1.712	2.361	11	1.371	1.205	2.007	2.177	4	1.915	1.296	2.889	2.441	11	1.473	1.599
Avg time for processing claim in days	17	17	27	10	13	19	18	4	9	11	13	18	5	9	11
% of electronic claims processed in 30 days	96.3%	92.2%	88.9%	99.2%	98.9%	95.7%	93%	91.7%	99%	98.5%	96.5%	94%	100%	99%	94.2%
% of electronic claims processed in 90 days	99.4%	99.4%	96.3%	99.9%	99.85%	99.5%	99%	100%	100%	99.99%	99.2%	99%	100%	100%	99.99%
Prior Authorization (PA)- Electronic															
# Received	180	2.236	689	103	2.439	135	2152	626	110	2.120	147	1984	653	129	2.153
# In Process	35	362	20	92	0	21	447	38	94	0	27	341	17	125	164
# Approved	140	1.920	669	88	1.979	109	1.877	562	88	1.727	116	1.881	627	109	1.791
# Denied	13	237	0	4	252	15	190	26	6	232	14	209	9	31	198
Avg time for PA in days	2	4	4	2	3	2	5	2	2	3	1	5	3	4	1
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1.705	507	0	1.765	88	1.531	495	0	1.745	63	1.557	477	0	1.725	55
# In Process	414	98	0	1.573	0	355	82	0	1.491	0	192	30	0	1.634	1
# Approved	1.228	449	0	1.550	79	1.140	461	0	1.474	52	1.296	493	0	1.849	44
# Denied	99	41	0	22	6	122	50	0	14	7	217	36	0	27	10
Avg time for PA in days	3	2	0	2	5	3	2	0	3	4	2	2	0	4	6
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3.124	5.885	492	6501	9.554	3.083	5.222	473	5449	9.171	3.295	5.410	430	5725	8.310
Air (by segment)	1.463	2.097	202	650	765	1.326	1.834	241	557	801	1.044	1.415	178	500	658
Public Transportation Pass (bus pass & handivan coupons)	1.994	1.127	714	2148	950	1.663	1.104	657	1938	876	1.084	1.152	300	1926	818
# Member Grievances															
# Received	12	9	19	33	44	20	10	13	22	40	20	6	11	23	30
# Resolved	11	6	13	25	24	17	11	20	10	42	22	9	10	15	40
# Outstanding	10	9	14	8	23	13	8	7	12	21	8	5	8	8	11
# Provider Grievances															
# Received	124	0	1	3	0	132	2	2	0	0	163	0	0	4	0
# Resolved	41	0	1	2	0	11	0	2	1	0	49	0	0	2	0
# Outstanding	497	0	0	1	0	620	2	0	0	0	728	2	0	2	0
# Member Appeals															
# Received	8	130	0	7	13	7	50	0	4	9	4	72	2	3	14
# Resolved	8	116	0	9	15	8	72	0	9	11	6	60	0	2	8
# Outstanding	8	43	0	7	11	7	21	0	3	9	2	33	0	4	15
# Provider Appeals															
# Received	22	5	0	64	131	50	18	0	109	91	46	29	0	52	89
# Resolved	19	13	0	105	101	1	11	0	138	123	7	23	0	44	113
# Outstanding	97	16	0	48	75	146	23	0	17	43	181	29	0	24	19
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1.000	80	81	4	134	243	65	72	4	130	177	63	56	4	118	172
Inpatient Acute Days * (A) - per 1.000	424	243	22	869	755	346	205	20	595	618	333	166	18	515	658
Readmissions within 30 days* (A)	47	148	26	45	38	42	104	24	34	41	44	83	15	40	27
ED Visits * (C) - per 1.000**	605	476	27	881	670	597	460	34	762	550	512	374	25	698	586
# Prescriptions (C) - per 1.000	8,793	10,619	671	46,970	13,359	8,663	10,140	634	12,130	13,883	9,232	10,762	716	13,500	14,659
Waitlisted Days * (A) - per 1.000	54	0	5	181	149	69	4	2	116	144	60	5	2	103	120
NF Admits * (A)	50	17	3	0	15	43	11	5	2	12	32	13	3	1	17
# Members in NF (non-Medicare paid days) (C)**	241	242	70	729	895	212	253	68	774	821	245	257	69	768	921
# Members in HCBS **(C)- note: member can be included in more than one category listed below	297	470	231	2066	1.428	313	465	229	2020	1.389	399	466	233	2027	1.312
# Members in Residential Setting **(C)	141	115	140	558	869	118	110	141	553	881	153	114	142	549	896
# Members in Self-Direction **(C)	82	176	40	783	335	82	171	39	741	296	82	171	43	740	246
# Members receiving other HCBS **(C)	159	355	191	1283	224	201	357	190	1279	213	246	354	190	1287	170
# Members in At-Risk ** (C)	641	551	112	851	979	650	578	116	749	952	668	591	117	788	1.017
# Members in Self-Direction **(C)	280	237	35	430	546	282	242	30	394	546	296	254	30	397	598
# Members receiving other HCBS **(C)	186	531	77	457	433	297	566	86	455	406	299	565	87	408	419
(* non-Medicare) (**lag in data of two months)															

	Apr-20					May-20					Jun-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	61.566	154.896	30349	27343	###### #	62.653	158.153	31399	27542	###### ##	63.173	161.310	32969	27931	###### ##
Duals	3.671	5.828	1341	9503	###### #	3.776	5.932	1364	9518	###### ##	3.849	6.084	1449	9522	###### ##
Total	65.237	160.724	31690	36846	50.729	66.429	164.085	32763	37060	53.259	67.022	167.394	34418	37453	53.435
# Network Providers															
PCPs	829	1.042	240	792	882	834	1.043	246	796	815	843	1.044	242	798	832
PCPs - (accepting new members)	699	829	226	579	643	702	832	232	583	564	711	834	230	586	578
Specialists	2.633	3.015	474	1547	1.501	2.698	3.027	476	1549	1.519	2.720	3.044	470	1549	1.521
Specialists (accepting new members)	1.842	3.015	474	992	1.354	1.873	3.027	476	994	1.371	1.896	3.044	470	994	1.374
Behavioral Health	857	1.674	124	668	1.040	861	1.679	134	668	1.030	862	1.677	134	668	1.030
Behavioral Health (accepting new members)	762	1.674	124	627	1.004	766	1.679	134	627	994	767	1.677	134	627	994
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	48	37	17	38	34	48	37	18	38	33	48	37	18	38	33
Residential Setting (CCFFH, E-ARCH, and ALF)	591	631	158	1042	1.196	597	633	150	1047	1.205	592	609	156	1047	1.205
HCBS Providers (except residential settings and LTSS facilities)	72	157	76	91	60	71	159	70	91	60	72	157	69	91	60
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1.902	2.473	123	1780	1.778	1.923	2.437	124	1780	1.772	1.941	2.438	126	1780	1.772
Total # of providers	**6.957**	**9.056**	**1224**	**5.982**	**6.514**	**7.057**	**9.042**	**1230**	**5.993**	**6.457**	**7.103**	**9.033**	**1227**	**5.995**	**6.476**
Call Center															
# Member Calls	3.213	5.161	322	3.939	3.400	3.010	5.563	353	4.285	3.110	3.903	6.559	422	5.181	3.985
Avg. time until phone answered	0:00:09	0:00:18	0:00:07	0:00:20	0:00:05	0:00:11	0:00:21	0:00:05	0:00:26	0:00:13	0:00:11	0:00:09	0:00:09	0:00:13	0:00:10
Avg. time on phone with member	0:05:33	0:06:45	5:08	0:08:15	0:06:44	0:06:49	0:06:56	5:40	0:08:31	0:07:25	0:06:39	0:06:50	5:45	0:08:01	0:07:52
% of member calls abandoned (member hung up)	0.22%	1.34%	0%	1%	0.20%	0.86%	1.67%	1%	2%	0.80%	0.51%	0.98%	1%	1%	0.60%
# Provider Calls	6.093	4.420	61	2.609	2.135	5.985	4.495	49	2.500	2.397	6.918	5.011	47	2.910	2.571
Avg. time until phone answered	0:00:12	0:00:24	0:00:03	0:00:07	0:00:09	0:00:18	0:00:25	0:00:01	0:00:08	0:00:13	0:00:21	0:00:10	0:00:10	0:00:10	0:00:04
Avg. time on phone with provider	0:06:22	0:08:21	6:06	0:09:36	0:07:30	0:06:41	0:07:43	9:42	0:09:24	0:07:11	0:06:16	0:07:14	3:25	0:09:27	0:06:54
% of provider calls abandoned (provider hung up)	0.33%	1.29%	0%	0%	0.00%	0.90%	1.71%	0%	1%	0.13%	1.30%	0.86%	0%	1%	0.27%
Medical Claims- Electronic															
# Submitted, not able to get into system	2.138	1.337	0	2.434	5.581	1.741	984	0	2.423	5.667	2.028	1.635	0	2.473	4.718
# Received	38.882	115.486	18076	46591	68.884	40.379	115.680	16780	46517	65.825	45.534	135.283	27756	50112	77.478
# Paid	37.399	122.910	16574	38246	75.056	34.011	97.397	15762	38432	65.035	44.572	112.161	26046	36927	66.083
# In Process	7.304	27.359	759	1892	6.407	11.657	36.105	325	2401	7.685	9.338	50.313	998	5922	7.936
# Denied	3.111	13.695	743	8788	10.502	2.286	9.488	693	9327	8.085	3.013	8.858	712	9421	7.325
Avg time for processing claim in days	6	9	1	6.75	7	7	9	1	7.27	4	7	8	1	6.96	4
% of electronic claims processed in 30 days	98%	98%	99.94	100%	99.3	98%	98%	99.99	99%	99.9	97%	98%	99.98	99%	100.0
% of electronic claims processed in 90 days	100%	100%	99.99	100%	100.0	99%	100%	100	100%	100.0	100%	100%	99.98	100%	100.0
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	300	861	1	111	2.178	262	1.031	4	151	1.718	293	993	0	326	615
# Received	12.004	13.172	12	3164	6.851	12.106	12.992	8	3170	6.155	13.776	15.480	3	9328	7.653
# Paid	12.559	14.896	9	1870	6.954	11.240	9.128	4	2165	6.085	13.114	12.137	2	4328	6.059
# In Process	4.480	5.277	0	135	1.169	4.938	6.985	0	410	1.493	4.332	8.182	0	4450	1.479
# Denied	1.935	3.181	3	829	2.087	1.977	2.128	4	1055	1.557	2.350	2.123	1	2388	1.546
Avg time for processing claim in days	13	16	4	10.39	8	15	15	29	11.61	4	13	14	4	10.23	5
% of electronic claims processed in 30 days	94%	93%	91.67	100%	99.1	95%	94%	87.50	100%	99.9	97%	95%	100.00	100%	99.9
% of electronic claims processed in 90 days	99%	98%	100	100%	100.0	98%	99%	87.50	100%	100.0	99%	99%	100.00	100%	100.0
Prior Authorization (PA)- Electronic															
# Received	143	1491	477	114	1.734	172	1811	493	123	2.182	198	2279	622	164	1.943
# In Process	15	285	13	108	125	27	333	3	116	171	36	331	10	151	149
# Approved	124	1.410	445	110	1.437	145	1.648	470	106	1.777	156	2.103	596	138	1.598
# Denied	20	137	19	2	172	15	115	20	16	176	19	178	16	20	196
Avg time for PA in days	0	5	3	1	1	0	4	2	1	0	1	3	3	1	0
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1.268	392	0	1.137	54	1.350	377	0	1.300	82	1.505	562	0	1.610	111
# In Process	165	35	0	1.099	17	231	37	0	1.203	10	291	25	0	1.477	26
# Approved	1.053	361	0	1.151	34	1.061	357	0	1.229	68	1.165	539	0	1.543	80
# Denied	114	26	0	36	3	109	18	0	14	3	105	35	0	31	5
Avg time for PA in days	1	1	0	1	1	1	1	0	2	1	1	2	0	2	2
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	2.381	3.559	390	4471	6.062	2.419	3.252	418	4404	6.329	2.890	4.151	501	4608	7.125
Air (by segment)	167	253	40	152	236	336	433	62	154	192	277	971	125	264	312
Public Transportation Pass (bus pass & handivan coupons)	842	558	413	1517	920	912	600	419	1558	789	1.025	944	513	1711	944
# Member Grievances															
# Received	15	9	11	24	18	19	8	16	15	30	21	15	15	21	29
# Resolved	19	5	11	15	29	13	9	19	11	40	23	9	14	9	17
# Outstanding	5	9	8	9	0	11	8	5	4	11	9	14	6	16	23
# Provider Grievances															
# Received	164	2	0	1	0	182	1	0	4	0	189	0	0	1	0
# Resolved	3	2	0	0	0	62	1	0	5	0	93	1	0	1	0
# Outstanding	890	2	0	1	0	987	2	0	4	0	1.047	1	0	0	0
# Member Appeals															
# Received	4	45	0	4	14	4	55	1	5	14	2	69	1	5	13
# Resolved	3	57	2	4	15	4	55	0	7	10	3	63	1	3	15
# Outstanding	3	21	0	3	14	3	20	1	1	8	2	32	1	3	6
# Provider Appeals															
# Received	41	5	0	37	135	24	11	0	28	105	35	13	0	58	61
# Resolved	1	17	0	46	101	20	10	0	28	118	19	17	0	34	81
# Outstanding	220	17	0	14	53	218	18	0	9	40	221	15	0	33	20
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1.000	48	42	3	75	156	58	64	4	79	61	59	70	3	104	62
Inpatient Acute Days * (A) - per 1.000	265	124	16	441	596	265	213	15	592	469	293	202	13	676	444
Readmissions within 30 days* (A)	20	57	11	36	21	30	112	19	42	25	40	140	23	51	33
ED Visits * (C) - per 1.000**	292	207	14	455	366	327	253	17	532	413	361	294	20	604	448
# Prescriptions (C) - per 1.000	7,582	8,886	487	11,840	12,604	6,899	8,620	476	11,206	13,339	7,314	8,953	524	11,441	12,847
Waitlisted Days * (A) - per 1.000	41	4	2	24	98	29	4	1	44	128	24	3	1	27	159
NF Admits * (A)	38	13	2	8	18	44	12	5	13	20	40	16	1	9	51
# Members in NF (non-Medicare paid days) (C)**	238	268	71	728	708	243	267	75	728	750	254	260	80	715	607
# Members in HCBS **(C)- note: member can be included in more than one category listed below	407	461	230	1996	1.508	276	466	245	1993	1.441	255	468	232	1965	1.433
# Members in Residential Setting **(C)	140	116	139	553	899	136	117	148	551	898	158	120	153	547	903
# Members in Self-Direction **(C)	85	167	42	728	312	88	171	42	709	279	85	173	38	680	272
# Members receiving other HCBS **(C)	273	346	188	1268	1.287	152	349	203	1284	1.242	101	344	194	1285	1.240
# Members in At-Risk ** (C)	699	627	124	790	1.318	709	638	130	818	1.407	734	647	133	786	1.371
# Members in Self-Direction **(C)	315	274	31	404	548	319	287	29	395	559	324	299	39	344	523
# Members receiving other HCBS **(C)	301	584	93	426	945	323	619	101	429	1.024	307	631	94	384	1.002

	Jul-20					Aug-20					Sep-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	64.110	164.341	34252	27966	###### ##	64.852	167.072	35792	28640	###### ##	65.696	169.921	37245	28127	###### ##
Duals	3.876	6.258	1518	9527	###### ##	3.935	6.448	1585	9535	###### ##	3.986	6.616	1650	9548	###### ##
Total	67.986	170.599	35770	37493	53.869	68.787	173.520	37377	38175	54.263	69.682	176.537	38895	37675	54.851
# Network Providers															
PCPs	834	1.050	239	798	871	832	1.046	234	805	871	818	1.051	242	809	902
PCPs - (accepting new members)	705	841	223	586	616	703	847	218	589	616	692	847	224	592	617
Specialists	2.739	3.092	469	1547	1.590	2.736	3.110	468	1548	1.590	2.746	3.190	469	1551	1.621
Specialists (accepting new members)	1.920	3.092	469	992	1.443	1.918	3.110	468	993	1.443	1.928	3.190	469	993	1.484
Behavioral Health	856	1.682	134	668	1.040	841	1.685	121	669	1.040	849	1.692	120	672	1.058
Behavioral Health (accepting new members)	752	1.682	134	627	1.004	752	1.685	121	627	1.004	763	1.692	120	627	1.023
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	15	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	48	37	17	38	32	48	37	17	38	32	46	37	15	38	33
Residential Setting (CCFFH, E-ARCH, and ALF)	596	613	158	1051	1.205	604	608	145	1052	1.205	624	609	145	1052	1.195
HCBS Providers (except residential settings and LTSS facilities)	71	156	73	91	60	76	156	72	91	60	78	151	71	91	57
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1.946	2.470	128	1780	1.786	1.939	2.478	122	1780	1.786	1.950	2.471	135	1780	1.802
Total # of providers	**7.115**	**9.127**	**1230**	**5.997**	**6.607**	**7.101**	**9.147**	**1191**	**6.007**	**6.607**	**7.136**	**9.228**	**1212**	**6.017**	**6.691**
Call Center															
# Member Calls	4.200	8.802	560	5.790	4.162	3.880	8.660	529	5.027	3.906	4.101	8.018	529	5.239	3.897
Avg. time until phone answered	0:00:09	0:00:22	0:00:09	0:00:20	0:00:12	0:00:09	0:00:07	0:00:09	0:00:35	0:00:09	0:00:09	0:00:09	0:00:07	0:00:19	0:00:16
Avg. time on phone with member	0:06:19	0:06:31	5:53	0:07:35	0:07:55	0:06:23	0:06:47	5:52	0:08:11	0:06:40	0:06:50	0:07:20	6:25	0:08:52	0:06:06
% of member calls abandoned (member hung up)	0.62%	2.07%	2%	2%	0.90%	0.67%	0.90%	1%	3%	1.50%	0.85%	1.22%	1%	2%	1.00%
# Provider Calls	7.074	6.015	70	3.043	2.581	6.518	5.544	76	2.615	2.318	6.665	5.594	84	2.683	2.406
Avg. time until phone answered	0:00:19	0:00:21	0:00:28	0:00:10	0:00:03	0:00:22	0:00:10	0:00:18	0:00:11	0:00:04	0:00:22	0:00:13	0:00:05	0:00:11	0:00:01
Avg. time on phone with provider	0:06:17	0:07:27	3:39	0:09:13	0:07:26	0:06:15	0:07:39	5:14	0:09:50	0:07:56	0:06:39	0:08:15	5:07	0:09:16	0:07:55
% of provider calls abandoned (provider hung up)	1.37%	1.41%	0%	2%	0.35%	1.92%	1.01%	0%	2%	0.35%	1.49%	1.16%	0%	1%	0.21%
Medical Claims- Electronic															
# Submitted, not able to get into system	2.514	1.687	0	2.610	3.890	2.004	1.640	0	2509	4.475	2.077	2.604	0	2610	3.587
# Received	49.205	150.635	28402	51372	77.582	48.771	149.693	31005	48325	80.621	49.117	154.656	34521	48607	80.150
# Paid	42.336	151.350	26210	46812	92.168	51.443	129.473	27291	43296	76.759	47.294	130.740	32207	41126	68.933
# In Process	14.140	38.163	1235	9780	13.033	7.648	48.444	2833	9619	1.391	6.605	62.210	1615	11640	1.695
# Denied	2.756	11.395	957	6762	7.933	3.148	9.939	881	5293	10.084	2.911	10.150	699	5312	9.309
Avg time for processing claim in days	7	9	1	5.7	4	6	9	1	6.1	6	7	9	1	5.75	5
% of electronic claims processed in 30 days	97%	98%	99.93	100%	100.0	98%	98%	99.96	100%	99.7	95%	98%	99.98	99.8	99.9
% of electronic claims processed in 90 days	100%	100%	99.95	100%	100.0	100%	100%	99.99	100%	100.0	100%	100%	100	99.9	100.0
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	256	1.947	0	285	849	270	1.239	3	102	1.148	286	1.424	4	116	501
# Received	14.588	14.283	12	4436	6.321	14.877	15.069	12	4007	7.208	14.359	14.688	8	3753	7.181
# Paid	13.292	14.056	7	5287	6.355	14.421	11.541	9	3439	5.679	14.009	10.401	8	2656	6.008
# In Process	5.425	6.338	1	1252	1.767	3.776	7.981	0	918	48	3.962	10.737	0	1238	150
# Denied	2.487	2.068	4	1592	1.375	2.038	1.885	3	922	1.406	1.861	1.531	0	781	1.409
Avg time for processing claim in days	12	15	1	9.85	4	11	14	62	10.35	6	11	16	20	10.5	5
% of electronic claims processed in 30 days	97%	94%	100.00	100%	99.8	98%	95%	75.00	99%	99.7	96%	94%	87.50	98.78	100.0
% of electronic claims processed in 90 days	99%	99%	100.00	100%	100.0	100%	99%	75.00	100%	100.0	100%	99%	87.50	99.36	100.0
Prior Authorization (PA)- Electronic															
# Received	183	2453	735	319	1.920	209	2298	690	771	1.810	202	2325	879	627	2.123
# In Process	24	332	31	192	156	26	401	20	272	138	62	338	44	514	134
# Approved	157	2.280	686	185	1.575	177	2.072	652	299	1.523	134	2.212	818	1.058	1.808
# Denied	32	172	18	20	189	44	157	18	16	149	61	176	17	13	181
Avg time for PA in days	0	3	3	2	1	1	4	2	8	0	1	4	3	15	2
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1.527	591	0	1.572	96	1.679	487	0	1.167	71	1.810	574	0	1.154	98
# In Process	267	32	0	1.421	6	306	30	0	1.011	10	417	40	0	1.056	8
# Approved	1.201	531	0	1.524	81	1.316	426	0	1.134	59	1.337	499	0	1.113	65
# Denied	137	53	0	33	9	152	63	0	31	2	146	65	0	35	7
Avg time for PA in days	1	2	0	3	4	2	2	0	4	4	2	2	0	5	4
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3.704	4.588	541	5108	7.574	3.237	4.113	536	4774	7.079	3.026	3.868	624	4845	7.125
Air (by segment)	826	1.142	184	348	375	417	691	134	371	304	310	463	70	190	231
Public Transportation Pass (bus pass & handivan coupons)	1.347	1.021	431	1753	993	1.130	1.030	351	1546	867	1.361	800	548	1483	976
# Member Grievances															
# Received	15	12	10	12	21	11	15	8	20	38	17	17	24	24	25
# Resolved	17	19	9	20	29	14	8	12	12	27	13	18	13	1	29
# Outstanding	7	7	7	8	15	4	14	3	8	26	8	13	14	23	22
# Provider Grievances															
# Received	97	0	23	5	0	113	4	51	0	0	73	0	422	0	0
# Resolved	188	1	20	4	0	237	0	51	0	0	156	1	390	0	0
# Outstanding	948	0	3	1	0	824	4	0	0	0	741	3	32	0	0
# Member Appeals															
# Received	3	86	1	5	5	7	55	1	5	7	1	59	0	4	13
# Resolved	2	84	1	6	10	5	71	1	4	8	5	55	1	4	7
# Outstanding	3	34	1	0	1	5	18	1	0	0	1	22	0	0	6
# Provider Appeals															
# Received	25	10	0	37	63	25	13	0	44	41	17	17	0	35	61
# Resolved	37	13	0	52	78	46	10	0	54	43	34	15	0	26	56
# Outstanding	210	12	0	17	5	189	15	0	7	3	172	17	0	10	8
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1.000	59	79	4	100	59	61	76	4	92	67	55	77	3	94	57
Inpatient Acute Days * (A) - per 1.000	271	232	20	712	446	329	229	20	628	469	271	248	17	636	412
Readmissions within 30 days* (A)	26	138	20	51	43	29	135	32	39	31	31	143	18	41	32
ED Visits * (C) - per 1.000**	376	312	22	612	477	386	296	21	594	458	354	268	19	528	425
# Prescriptions (C) - per 1.000	7,452	9,245	535	11,451	9,156	7,061	8,928	510	10,991	8,892	7,054	8,812	502	11,057	8,679
Waitlisted Days * (A) - per 1.000	24	2	1	51	160	34	2	3	39	174	30	4	2	17	117
NF Admits * (A)	42	16	0	12	35	49	14	4	15	30	41	14	2	12	30
# Members in NF (non-Medicare paid days) (C)**	258	270	83	696	726	262	279	91	645	720	233	280	91		706
# Members in HCBS **(C)- note: member can be included in more than one category listed below	283	474	218	1999	1.483	304	480	216	1889	1.457	274	400	215	1874	1.383
# Members in Residential Setting **(C)	141	124	134	534	928	157	129	146	513	887	165	141	141	499	878
# Members in Self-Direction **(C)	85	172	38	749	281	87	178	42	737	281	85	132	42	691	245
# Members receiving other HCBS **(C)	134	346	180	1250	1.287	153	375	174	1152	1.258	109	258	173	1183	139
# Members in At-Risk ** (C)	751	666	137	887	1.374	769	684	142	892	1.349	789	820	147	872	737
# Members in Self-Direction **(C)	328	302	39	380	503	332	325	36	385	489	339	397	37	393	454
# Members receiving other HCBS **(C)	316	651	98	397	1.038	364	760	106	402	997	323	801	110	444	287

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility

Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.

PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

CMS 1500- physicians, HCBS providers eg.case management agencies, CCFFH/EARCH/ALF, home care agencies , 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.

QUEST Integration Health Plan Demographic Information by Island as of: 9/30/2020

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	468	83	22	12	66	81	86	818
PCPs - (accepting new members)	**392**	**72**	**19**	**10**	**55**	**69**	**75**	**692**
Specialists*	2000	281	25	0	175	77	188	2746
members)	**1415**	**181**	**12**	**0**	**119**	**55**	**146**	**1928**
Behavioral Health*	531	115	10	3	47	80	63	849
Behavioral Health (accepting new members)	**468**	**107**	**10**	**3**	**44**	**75**	**56**	**763**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	27	3	0	1	6	5	4	46
Residential Setting (CCFFH, E-ARCH, and ALF)	518	29	1	0	10	51	15	624
HCBS Providers (except residential settings and LTSS facilities)	41	10	4	3	5	10	5	78
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1256	241	27	14	142	129	141	1950
Totals	**4853**	**764**	**90**	**34**	**454**	**434**	**507**	**7136**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	39430	8780	2274	480	5722	6614	6382	**69682**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	84	106	103	40	87	82	74	85

Note: RFP requirement is 300 members for every PCP

HMSA

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	665	91	15	14	64	100	102	1,051
PCPs - (accepting new members)	525	69	13	9	50	86	95	**847**
Specialists*	1,921	309	70	43	177	318	352	3,190
members)	**1,921**	**309**	**70**	**43**	**177**	**318**	**352**	**3,190**
Behavioral Health*	1,054	203	8	7	93	192	135	1,692
Behavioral Health (accepting new members)	**1,054**	**203**	**8**	**7**	**93**	**192**	**135**	**1,692**
Hospitals	14	2	1	1	3	1	5	27
LTSS Facilities (Hosp./NF)	25	2	1	0	3	5	1	37
Residential Setting (CCFFH, E-ARCH, and ALF)	483	28	1	0	12	64	21	609
HCBS Providers (except residential settings and LTSS facilities)	71	18	8	6	13	24	11	151
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,589	267	32	21	172	167	223	2,471
Totals	**5.822**	**920**	**136**	**92**	**537**	**871**	**850**	**9.228**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	103158	12889	918	174	12038	28120	19240	**176,537**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	155	142	61	12	188	281	189	168

Note: RFP requirement is 300 members for every PCP

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	180	62						242
PCPs - (accepting new members)	**171**	**53**						**224**
Specialists*	373	96						469
members)	**373**	**96**						**469**
Behavioral Health*	102	18						120
Behavioral Health (accepting new members)	**102**	**18**						**120**
Hospitals	13	2						15
LTSS Facilities (Hosp./NF)	14	1						15
Residential Setting (CCFFH, E-ARCH, and ALF)	131	14						145
HCBS Providers (except residential settings and LTSS facilities)	56	15						71
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	96	39						135
Totals	**965**	**247**	**0**	**0**	**0**	**0**	**0**	**1212**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	25942	12953						**38895**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	144	209	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	161

Note: RFP requirement is 300 members for every PCP

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	552	51	9	10	73	71	43	809
PCPs - (accepting new members)	411	35	9	10	59	36	32	**592**
Specialists*	1168	108	13	4	113	76	69	1551
members)	708	88	13	4	53	66	61	**993**
Behavioral Health*	467	49	4	0	34	74	44	672
Behavioral Health (accepting new members)	448	34	3	0	34	68	40	**627**
Hospitals	11	2	1	1	3	1	5	24
LTSS Facilities (Hosp./NF)	23	3	1	1	5	2	3	38
Residential Setting (CCFFH, E-ARCH, and ALF)	883	41	0	0	18	85	25	1052
HCBS Providers (except residential settings and LTSS facilities)	51	8	2	0	4	20	6	91
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1120	180	15	6	131	172	156	1780
Totals	**4275**	**442**	**45**	**22**	**381**	**501**	**351**	**6017**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	23763	3808	403	97	2010	4638	2956	**37675**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	43	75	45	10	28	65	69	47

Note: RFP requirement is 300 members for every PCP

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	565	73	12	6	61	72	58	847
PCPs - (accepting new members)	**411**	**30**	**7**	**4**	**55**	**43**	**36**	**586**
Specialists*	1.246	165	65	9	111	199	175	1.970
members)	**1.130**	**151**	**49**	**9**	**102**	**185**	**164**	**1.790**
Behavioral Health*	759	245	61	64	169	239	201	1.738
Behavioral Health (accepting new members)	**732**	**242**	**61**	**64**	**166**	**236**	**198**	**1.699**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	23	2	0	0	3	4	1	33
Residential Setting (CCFFH, E-ARCH, and ALF)	983	53	2	0	23	110	24	1.195
HCBS Providers (except residential settings and LTSS facilities)	44	9	1	0	7	17	5	83
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1.300	247	15	12	142	186	160	2.062
Totals	**4930**	**797**	**157**	**92**	**519**	**831**	**627**	**7.953**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	36.053	4.694	274	98	2.984	6.941	3.807	**54.851**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	64	64	23	16	49	96	66	65

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls

as of: 9/30/2020

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	74	10	2	0	7	12	5	**110**
Network (provider look up, access)	84	12	2	0	5	9	2	**114**
Primary Care Physician Assignment or Change	262	45	3	0	32	37	19	**398**
NEMT (inquiry, scheduling) -*monthly report*	427	32	10	5	12	48	22	**556**
Authorization/Notification (prior auth status)	525	44	12	2	24	50	16	**673**
Eligibility (general plan eligiblity, change request)	471	47	5	2	21	44	28	**618**
Benefits (coverage inquiry)	238	31	4	5	23	29	17	**347**
Enrollment (ID card request, update member information)	49	1	0	0	3	4	0	**57**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	294	26	2	0	14	24	14	**374**
Billing/Payment/Claims	652	60	4	1	19	24	13	**773**
Appeals	24	1	0	0	0	0	0	**25**
Complaints and Grievances	4	1	0	0	0	0	0	**5**
Other	218	39	2	2	13	26	5	**305**
Totals	**3,322**	**349**	**46**	**17**	**173**	**307**	**141**	**4,355**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	16	1	0	0	1	4	0	**22**
Network (provider look up, access)	123	17	0	0	14	28	23	**205**
Primary Care Physician Assignment or Change	1473	144	9	2	171	277	284	**2360**
NEMT (inquiry, scheduling) -*monthly report*	194	72	12	7	45	149	176	**655**
Authorization/Notification (prior auth status)	30	2	0	0	2	15	15	**64**
Eligibility (general plan eligiblity, change request)	350	50	3	2	38	74	68	**585**
Benefits (coverage inquiry)	325	71	2	0	37	57	62	**554**
Enrollment (ID card request, update member information)	675	74	2	1	75	186	144	**1157**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	24	6	0	0	1	8	8	**47**
Billing/Payment/Claims	170	25	1	0	20	22	39	**277**
Appeals	1	1	0	0	0	0	0	**2**
Complaints and Grievances	5	1	1	0	1	3	0	**11**
Other	420	76	3	0	62	112	116	**789**
Totals	**3806**	**540**	**33**	**12**	**467**	**935**	**935**	**6728**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	3	0						**3**
Network (provider look up, access)	31	13						**44**
Primary Care Physician Assignment or Change	3	3						**6**
NEMT (inquiry, scheduling) -*monthly report*	14	0						**14**
Authorization/Notification (prior auth status)	1	0						**1**
Eligibility (general plan eligiblity, change request)	164	34						**198**
Benefits (coverage inquiry)	104	39						**143**
Enrollment (ID card request, update member information)	32	11						**43**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	17	6						**23**
Appeals	0	0						**0**
Complaints and Grievances	0	0						**0**
Other	119	19						**138**
Totals	**488**	**125**	**0**	**0**	**0**	**0**	**0**	**613**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	289	50	3	0	11	94	22	**469**
Network (provider look up, access)	55	4	0	0	2	5	4	**70**
Primary Care Physician Assignment or Change	81	12	0	0	3	20	12	**128**
NEMT (inquiry, scheduling) -*monthly report*	1358	288	39	17	4	38	8	**1752**
Authorization/Notification (prior auth status)	21	13	10	0	2	24	7	**77**
Eligibility (general plan eligiblity, change request)	39	4	0	0	0	17	3	**63**
Benefits (coverage inquiry)	138	23	3	0	15	34	11	**224**
Enrollment (ID card request, update member information)	207	22	7	0	11	65	17	**329**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	88	12	3	0	3	32	6	**144**
Billing/Payment/Claims	25	5	0	0	0	11	3	**44**
Appeals	8	1	0	0	1	7	3	**20**
Complaints and Grievances	13	4	0	0	0	5	0	**22**
Other	1031	169	22	0	37	254	67	**1580**
Totals	**3,353**	**607**	**87**	**17**	**89**	**606**	**163**	**4,922**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	152	18	1	0	11	26	15	**223**
Network (provider look up, access)	70	18	0	0	5	28	6	**127**
Primary Care Physician Assignment or Change	428	75	2	5	45	116	63	**734**
NEMT (inquiry, scheduling) -*monthly report*	59	8	2	1	2	22	14	**108**
Authorization/Notification (prior auth status)	75	20	1	0	4	23	15	**138**
Eligibility (general plan eligiblity, change request)	413	50	0	4	24	92	43	**626**
Benefits (coverage inquiry)	537	61	0	1	42	86	52	**779**
Enrollment (ID card request, update member information)	138	23	0	0	6	29	13	**209**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	113	22	2	0	15	22	12	**186**
Billing/Payment/Claims	3	1	0	0	0	1	0	**5**
Appeals	8	1	0	0	3	4	1	**17**
Complaints and Grievances	4	0	0	0	0	0	0	**4**
Other	464	57	8	0	40	101	59	**729**
Totals	**2,464**	**354**	**16**	**11**	**197**	**550**	**293**	**3,885**

Health plan shall highlight changes made for the previous month(s)

# Members	Description of Information to Include
Medicaid	Number of members receiving QI benefit package who do not have Medicare primary
Duals	Number of members receiving dual benefits
Total	Total number of members
# Network Providers	**Providers count on the "Dashboard" sheet should be un-duplicated. The providers counts on the "HP Demographics by Island" sheet may be duplicated when an individual provider serves multiple islands. Providers such as pharmacy services may be counted based upon number of locations. Non-Hawaii based network providers shall be excluded from all counts.**
PCPs	PCP count includes PCPs in the clinics. Utilize the definition provided on the Report Tool
PCPs - (accepting new members)	Number of PCPs (includes PCPs in clinics) accepting new members
Specialists	All specialists as defined in Section 40.220
Specialists (accepting new members)	Number of Specialists accepting new members
Behavioral Health	All behavioral health providers as defined in Section 40.220
Behavioral Health (accepting new members)	Number of Behavioral Health providers accepting new members
Hospitals	All hospitals
LTSS Facilities (Hosp./NF)	All facilities that have residents receiving LTSS (both hospital-based and free-standing nursing facilities)
Residential Setting (CCFFH, E-ARCH, and ALF)	All residential settings (CCFFH, E-ARCH, and ALF)
HCBS Providers (except residential settings and LTSS facilities)	All other HCBS providers as defined in Section 40.220 excluding those that are residential settings of LTSS facilities
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	All ancillary providers to include pharmacies, laboratories, therapists, hospice, home health agencies.
Total # of providers	Total of all providers listed
	Note: all providers in the QI network should be included. There should be no duplication of provider counts per category. If type is not listed, add provider type to the "Ancillary & Other" section.
Call Center	
# Member Calls	# of calls received from members
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with member	Average time on the phone with member in minutes and seconds
% of member calls abandoned (member hung up)	Percent of member calls abandoned
# Provider Calls	# of calls received from providers
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with provider	Average time on the phone with provider in minutes and seconds
% of provider calls abandoned (provider hung up)	Percent of provider calls abandoned
Medical Claims- Electronic	**Note: (1) A " Processed claim" is a QI claim (not based on # of items/lines in the claim) that "PAID" or "DENIED" in the reporting period. Health plan shall determine how a claim is considered "PAID" or "DENIED". (2) When a single claim that has multiple RECEIVED/PAID/DENIED dates, health plan should use the LAST DATE that the final "PAID" or "DENIED" item/line is made for the 30/90 days calculation because this will be a "completely" processed claim.**
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of electronic claims processed in 30 days
% of claims processed in 90 days	% of electronic claims processed in 90 days
(month to date)	
Medical Claims- Paper	
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month

Measure	Definition
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of paper claims processed in 30 days
% of claims processed in 90 days	% of paper claims processed in 90 days
(month-to-date)	
Prior Authorization (PA)- Electronic	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month to date)	
Prior Authorization (PA)- Paper and Telephone	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month-to-date)	
# Non-Emergency Transports	
Ground (# of round trips)	# of ground trips for non-emergency transports. A roundtrip is counted as one (i.e., to MD appointment and home is one (1) trip not two (2) trips)
Air (by segment)	# of air trips (by segment) for non-emergency transports i.e. fly from Maui to HNL and back count as 2 segments
Public Transportation Pass (bus pass & handivan coupons)	# of bus passes or handivan coupons issued
# Member Grievances	
# Received	# of member grievances received in the month
# Resolved	# of member grievances resolved in the month
# Outstanding	# of outstanding member grievances at the end of the month Note: The number of member grievances outstanding in this month is the number of member grievances outstanding in the prior month plus the number of member grievances received in this month minus the number of member grievances resolved in this month.
# Provider Grievances	
# Received	# of provider grievances received in the month
# Resolved	# of provider grievances resolved in the month
# Outstanding	# of outstanding provider grievances at the end of the month Note: The number of provider grievances outstanding in this month is the number of provider grievances outstanding in the prior month plus the number of provider grievances received in this month minus the number of provider grievances resolved in this month.
# Member Appeals	
# Received	# of member appeals received in the month
# Resolved	# of member appeals resolved in the month
# Outstanding	# of outstanding member appeals at the end of the month Note: The number of member appeals outstanding in this month is the number of member appeals outstanding in the prior month plus the number of member appeals received in this month minus the number of member appeals resolved in this month.
# Provider Appeals	
# Received	# of provider appeals received in the month
# Resolved	# of provider appeals resolved in the month
# Outstanding	# of outstanding provider appeals at the end of the month Note: The number of provider appeals outstanding in this month is the number of provider appeals outstanding in the prior month plus the number of provider appeals received in this month minus the number of provider appeals resolved in this month.
Utilization - based on Auth (A) or Claims (C)	
Inpatient Acute Admits * (A) - per 1,000	# of inpatient acute admits (based on authorizations) in the month per 1,000 members

Measure	Definition
Inpatient Acute Days * (A) - per 1,000	# of inpatient acute days (based on authorizations) in the month per 1,000 members
Readmissions within 30 days* (A)	# of readmissions within thirty (30) days in the month based upon authorizations
ED Visits* (C) - per 1,000**	# of ER visits in the previous month (based upon claims) per 1,000. For example, if reporting is on September 15th for August, provide data for July ER visits.
# Prescriptions (C) - per 1,000	# of prescriptions in the month (based upon claims) per 1,000 members
Waitlisted Days* (A) - per 1,000	# of waitlisted days in the month (based upon authorizations) per 1,000 members
NF Admits * (A)	Authorized Non-Medicare nursing facility admissions
# Members in NF (non-Medicare paid days)**(C)	Non-Medicare paid days (claims based)
# Members in HCBS **(C)	# of members in HCBS (exculdes members in at-risk) in the month (based upon claims). Member can be included in more than one category listed below. Note: (1) The listing of HCPCS codes listed on the LTSS Report (Tab D. Auth by Service Code) shall be used to determine those HCPCS codes categorized as 'HCBS' (2) The # of members in HCBS (C) will be based solely on paid claims during the reporting period. This determination will be made irrespective of the member's "1148" status/facility code (e.g. "299")
# Members in Residential Setting **(C)	# of HCBS members in Residential Setting (based upon claims). Note: Based solely on paid claims against HCPCS S5140, T2033 and T2031.
# Members in Self-Direction **(C)	# of HCBS members in Self-Direction (based upon claims)
# Members receiving other HCBS **(C)	# of HCBS members receiving other HCBS servcies (based upon claims) as defined in Section 40.740.3
# Members in At-risk**(C)	# of members in At-risk in the month (based upon claims). Note: The population of At-risk members will be based on a member having an active "at-risk" coded 1147 (i.e. Level of Care Approval Status = 11). Only those with paid claims against HCBS codes noted above shall be included.
# Members in Self-Direction ** (C)	# of At-risk members in Self-Direction in the month (based upon claims)
# Members receiving other HCBS** (C)	# of At-risk members receiving other HCBS services (based upon claims)
	Note: Non-Medicare is for acute, ED, and prescriptions. Health plans should report on acute waitlisted, Medicaid primary NF, and all HCBS (even if these individuals are duals).

(*Non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility
Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.
PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

ATTACHMENT C

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 4/2020

State: Hawaii

Summary of Expenditures by Waiver Year
Waiver: 11W00000

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disabled withou	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disabled withou	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Summary of Expenditures by Waiver Year
Waiver: 11W00001

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	70,981,761	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,981,761	70,981,761
1902 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(8,243,749)	(8,243,749)
1902R2	0	121,392	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	121,392	121,392
AFDC	0	148,069,654	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	148,069,654	148,069,654
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(295)	121,279,464	314,952,648	350,714,627	326,518,117	349,156,948	184,750,729	364,919,444	307,865,937	320,856,325	332,285,621	556,431,345	364,714,483	64,039,696	0	0	0	3,958,485,089	3,958,485,089
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,424,989	17,555,107	24,914,002	19,728,957	24,483,589	14,925,306	37,994,811	48,712,106	46,535,285	55,786,925	84,337,947	64,326,264	12,051,993	0	0	0	453,777,281	453,777,281
Aged with Medicare -	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(473,188)	(505,165)	(397,775)	(598,936)	(474,228)	0	0	0	0	(2,449,292)	(2,449,292)
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(14,668)	(44,822)	(62,495)	(43,976)	(17,253)	0	0	0	0	(183,214)	(183,214)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(13,736)	31,794,652	74,760,519	81,089,359	77,504,607	88,201,319	49,105,356	98,847,286	163,362,887	158,584,686	155,598,645	244,914,264	147,887,636	25,827,781	0	0	0	1,397,465,261	1,397,465,261
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(28,991)	81,514,842	211,664,665	248,689,322	257,028,809	282,670,355	148,440,400	290,201,067	285,336,958	310,399,367	342,048,447	473,294,409	336,314,844	61,962,769	0	0	0	3,329,537,263	3,329,537,263
Blind/Disable without	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(324,738)	(333,645)	(370,635)	(399,762)	(285,331)	0	0	0	0	(1,714,111)	(1,714,111)
Blind/Disabled with M	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(61,110)	(74,223)	(153,925)	(230,511)	(80,659)	0	0	0	0	(600,428)	(600,428)
Breast Cervical Cance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	4,053	545,332	904,018	750,145	365,104	585,589	277,616	222,869	103,847	107,788	52,983	15,411	0	0	0	3,934,753	3,934,753
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	730,733,483	730,733,483
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	272,778,438	272,778,438
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40,064,795	40,064,795
Demo Elig Adults	0	0	0	0	0	0	0	0	134,638	1,995	51,709	318,560	127,982,800	129,456,848	154,209,257	177,392,619	201,628,981	238,945,778	244,752,500	227,394,155	43,950,943	55,913	(5,724)	735	0	0	0	0	0	0	0	1,546,271,707	1,546,271,707
Expansion State Adult	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	191,925,290	343,651,347	477,526,936	546,471,295	785,972,863	533,568,145	102,364,785	0	0	0	2,981,480,661	2,981,480,661
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	91,499	83,366	94,158	137,403	73,022	176,324	173,482	703,614	618,274	885,664	1,318,600	2,269,310	1,688,771	301,633	0	0	0	8,615,120	8,615,120
HawaiiQuest-1902(R)	0	700,529	107,270	2,484,576	1,636,854	860,335	1,594,466	0	0	284	34,836	438,582	0	0	33,061	26,332	8,001	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,925,126	7,925,126
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135,520	683,159	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	818,679	818,679
HealthQuest-Current	0	3,884,748	350,430	12,121,771	10,002,019	7,377,643	10,651,130	9,373,702	64,428,704	230,593,470	268,955,153	392,471,288	(2,325,152)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,007,884,906	1,007,884,906
HealthQuest-Others	0	1,783,163	215,685	5,322,833	3,698,445	2,678,918	3,915,013	3,306,673	21,010,550	63,645,959	99,234,046	93,729,117	(621,643)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	297,918,759	297,918,759
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	56,504	120,767	115,693	58,345	117,005	109,837	8,305	0	0	0	0	0	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,715	3,960	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	122,839	581,513	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,050,612	165,225,916	110,172,746	129,039,016	188,021,506	115,986,324	21,506,059	0	0	0	947,003,510	947,003,510
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,100,418	16,199,737	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	76,678	103,084	80,075	257,166	253,182	31	0	0	0	0	0	0	0	0	0	0	0	0	0	770,216	770,216
Others	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	376,237,032	376,237,032
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	0	(15,309,727)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(15,309,727)	(15,309,727)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(2,751)	798,681	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205	76,432,838	26,173,447	106,232	0	0	0	0	0	0	0	0	0	205,854,785	205,854,785
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862,479	17,432,949	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Imm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,990	2,628,840	2,628,927	2,873,646	987,921	1,532,329	1,448,764	2,048,646	2,315,023	4,043,498	3,065,981	430,430	0	0	0	24,028,995	24,028,995
State Plan Adults	0	0	0	0	0	0	0	0	(10)	218	99	39,158	111,982,730	118,021,622	109,034,691	128,225,118	131,863,143	123,596,289	112,790,909	130,112,852	80,834,554	202,368,440	172,913,238	169,042,108	182,900,835	252,985,641	164,588,606	31,863,396	0	0	0	2,223,163,637	2,223,163,637
State Plan Children	0	0	0	0	0	0	0	(41)	(9,403)	2,008	878	2,541,467	181,803,051	179,672,723	155,392,585	168,853,209	202,959,370	213,968,923	187,874,968	215,942,758	106,595,650	248,572,791	306,184,516	316,589,798	372,772,425	583,608,263	380,433,440	65,598,485	0	0	0	3,889,357,864	3,889,357,864
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	7,500,002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,500,002	7,500,002
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	17,822,210	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	15,688,221	22,546,108	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842	12,164,879	5,856,911	10,090,466	6,184,588	981,179	0	0	0	0	0	0	0	216,220,054	216,220,054
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	609,561	0	0	0	0	0	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	10,056,500	3,403,710	7,500,000	7,500,000	7,500,000	7,500,000	0	38,818,619	39,694,442	82,153,936	85,515,739	66,000,000	0	0	0	0	0	0	0	355,642,946	355,642,946
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	71,468,225	(8,863)	0	0	0	0	0	0	0	0	0	71,459,362	71,459,362
Total	**0**	**1,430,419,192**	**673,385**	**19,929,180**	**15,337,318**	**10,916,896**	**18,580,159**	**228,727,963**	**244,800,211**	**294,243,934**	**368,276,721**	**514,860,384**	**444,696,938**	**454,123,543**	**464,250,373**	**785,020,500**	**1,211,765,023**	**1,357,369,890**	**1,307,250,747**	**1,449,178,427**	**773,323,801**	**1,747,098,957**	**1,886,418,458**	**1,978,888,489**	**2,119,655,849**	**3,174,713,649**	**2,111,770,006**	**385,962,438**	**0**	**0**	**0**	**24,798,252,431**	**24,798,252,431**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	35,490,882	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35,490,882	35,490,882
1902 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	60,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	0	74,034,827	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74,034,827	74,034,827
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(199)	81,134,508	211,362,743	229,319,379	165,433,841	179,767,116	95,671,244	189,594,082	162,182,080	173,947,428	182,375,956	302,237,727	208,697,277	38,212,487	0	0	0	2,219,935,669	2,219,935,669
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,622,988	11,822,762	16,022,396	9,984,628	12,621,590	7,728,650	19,714,969	25,630,796	25,194,791	30,581,769	45,665,494	36,921,822	7,191,424	0	0	0	250,704,079	250,704,079
Aged with Medicare -	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(249,679)	(273,613)	(218,333)	(324,766)	(268,101)	0	0	0	0	(1,334,492)	(1,334,492)
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,720)	(24,377)	(34,310)	(23,817)	(9,392)	0	0	0	0	(99,616)	(99,616)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(9,251)	21,277,328	49,857,636	52,547,252	39,129,038	45,400,574	25,392,157	51,341,230	86,036,126	85,942,520	85,381,721	133,031,444	84,577,239	15,411,437	0	0	0	775,316,451	775,316,451
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(19,525)	54,511,233	141,799,152	161,274,589	130,207,936	145,622,789	76,872,883	150,336,282	149,646,906	167,640,879	187,306,580	255,487,844	192,322,407	36,973,186	0	0	0	1,849,983,141	1,849,983,141
Blind/Disable without	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(171,495)	(180,813)	(203,447)	(216,481)	(160,969)	0	0	0	0	(933,205)	(933,205)
Blind/Disabled with M	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(32,236)	(40,358)	(84,504)	(125,175)	(45,312)	0	0	0	0	(327,585)	(327,585)
Breast Cervical Cance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1)	2,754	361,286	592,247	495,478	241,945	376,275	201,477	152,695	77,771	62,593	34,490	9,196	0	0	0	2,608,206	2,608,206
CURRENT	0	247,684,665	0	0	0	0	904,176	83,526,544	40,668,142	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	372,783,527	372,783,527
CURRENT POP	0	136,389,220	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	136,389,220	136,389,220
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	0	0	0	0	0	0	0	0	79,127	1,144	30,236	186,922	75,196,276	74,766,107	87,642,204	114,378,784	135,452,513	154,819,222	123,131,091	116,746,726	22,522,276	29,051	(3,183)	397	0	0	0	0	0	0	0	904,978,893	904,978,893
Expansion State Adult	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	157,575,707	316,564,065	458,125,253	506,885,661	730,096,646	485,962,666	92,128,307	0	0	0	2,747,338,305	2,747,338,305
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51,916	53,413	63,415	89,013	36,291	90,804	89,632	365,633	326,044	480,663	723,548	1,231,959	966,284	179,985	0	0	0	4,748,600	4,748,600
HawaiiQuest-1902(R)	0	353,988	53,702	1,242,907	818,930	430,573	808,769	0	0	166	20,369	256,468	0	0	18,679	19,755	5,389	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76,578	438,797	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	1,963,002	175,736	6,063,866	5,004,058	3,692,366	5,386,340	4,903,637	36,087,606	132,768,282	165,985,082	231,578,381	(1,365,848)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	901,053	107,974	2,662,739	1,849,641	1,340,727	1,981,352	1,733,011	11,768,154	36,642,802	60,584,431	55,313,761	(363,962)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	32,497	68,553	68,082	38,985	78,049	64,590	4,238	0	0	0	0	0	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,196	2,666	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69,404	368,050	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,032,614	165,225,680	110,132,233	122,629,623	176,007,124	105,676,213	19,355,453	0	0	0	916,060,271	916,060,271
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,881,647	10,235,011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	44,819	59,404	45,487	166,217	170,408	21	0	0	0	0	0	0	0	0	0	0	0	0	0	486,356	486,356
Others	0	144,525,295	0	0	0	0	426,612	29,580,209	16,428,385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	190,960,501	190,960,501
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	0	(7,809,492)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,809,492)	(7,809,492)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(1,583)	454,606	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685	39,331,445	13,397,540	55,183	0	0	0	0	0	0	0	0	0	115,390,826	115,390,826

ATTACHMENT C

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 4/2020

RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,442,944	10,922,768	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St PI Adults-Preg Imm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,829	1,707,938	1,317,977	1,473,988	508,843	795,526	764,288	1,111,786	1,270,634	2,194,658	1,756,344	256,838	0	0	0	13,175,649	13,175,649
State Plan Adults	0	0	0	0	0	0	0	0	(6)	125	52	22,986	65,812,117	68,288,552	61,892,816	82,540,889	88,651,957	80,730,594	56,365,779	66,741,085	41,647,599	104,845,589	90,882,653	91,217,054	100,249,540	136,997,743	94,158,843	19,012,889	0	0	0	1,250,058,856	1,250,058,856
State Plan Children	0	0	0	0	0	0	0	(23)	(5,530)	1,173	507	1,494,521	106,725,591	103,797,242	88,086,005	108,850,847	136,539,237	138,140,612	92,677,457	110,463,464	54,513,194	128,939,345	161,395,719	171,534,913	204,479,908	316,700,343	217,875,713	39,142,615	0	0	0	2,181,352,853	2,181,352,853
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	4,385,251	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,385,251	4,385,251
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	10,614,749	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	9,212,484	13,041,165	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917	6,249,536	3,037,111	5,240,639	3,261,810	529,641	0	0	0	0	0	0	0	125,000,399	125,000,399
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	307,706	0	0	0	0	0	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	5,787,516	1,958,835	4,237,500	4,959,750	5,051,250	4,697,250	0	20,131,336	20,583,506	42,677,271	45,049,870	35,626,800	0	0	0	0	0	0	0	190,760,884	190,760,884
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37,060,184	(4,595)	0	0	0	0	0	0	0	0	0	37,055,589	37,055,589
Total	**0**	**716,158,823**	**337,412**	**9,969,512**	**7,672,629**	**5,463,666**	**9,493,195**	**119,743,378**	**135,002,643**	**169,413,692**	**226,620,677**	**303,853,039**	**261,079,907**	**262,434,464**	**263,479,344**	**510,938,536**	**813,433,104**	**881,694,769**	**657,883,831**	**745,135,931**	**399,268,095**	**1,068,914,801**	**1,206,703,201**	**1,321,117,892**	**1,421,422,117**	**2,099,023,336**	**1,428,465,524**	**267,873,817**	**0**	**0**	**0**	**15,312,597,335**	**15,312,597,335**

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	63,695,860	0	0	0	0	1,013,990,557	1,013,990,557
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214	12,833,291	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,241,969**	**42,748,419**	**40,068,477**	**45,961,643**	**56,826,439**	**59,479,815**	**54,588,745**	**85,205,753**	**62,594,608**	**82,954,286**	**118,530,760**	**105,382,868**	**97,409,012**	**139,266,156**	**63,695,860**	**0**	**0**	**0**	**0**	**1,061,954,810**	**1,061,954,810**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	16,364,026	0	0	0	733,753,927	733,753,927
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187	6,534,554	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,679,980**	**22,272,827**	**21,285,217**	**23,906,078**	**31,788,472**	**34,488,282**	**31,963,518**	**59,588,869**	**48,414,408**	**61,342,106**	**93,307,850**	**78,500,894**	**71,800,158**	**98,697,486**	**61,050,371**	**16,364,026**	**0**	**0**	**0**	**758,450,542**	**758,450,542**

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	26
Budget Neutrality Reporting End DY	30

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	420,331	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	339,459	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	285,411	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,431,735,669**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,307,865,902**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 382,122,211	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,531,974,433
EG 2 - Adults	2		$ 167,707,570	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,178,405,101
EG 3 - Aged	3		$ 386,679,546	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,178,185,372
EG 4 – Blind/Disabled	4		$ 479,759,681	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,168,903,373
TOTAL			**$ 1,416,269,008**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,498,357,192**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 382,122,211	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 246,926,601	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 185,194,950	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 167,707,570	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 221,296,161	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 165,972,120	$ 206,452,113	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 386,679,546	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 271,589,163	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 203,691,873	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 479,759,681	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 275,654,737	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 206,741,053	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 761,599,996**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,357,131,533**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 253,866,665**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,452,377,178**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,452,377,178**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,670,135,673	$ 3,596,043,074	$ 5,614,959,229	$ 7,731,553,088	$ 9,950,734,370	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,402,713	$ 53,940,646	$ 56,149,592	$ 38,657,765	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (253,866,665)	$ (532,290,490)	$ (824,375,504)	$ (1,130,824,751)	$ (1,452,377,178)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,269,833,094	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,269,833,094**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,852,609,967**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$649,554,469	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 649,554,469**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,339,774,396**
HYPOTHETICALS VARIANCE 1			**$ 620,278,625**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,512,835,571**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 3,913,204	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 3,913,204**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 20,198,305**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 3,807,889	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 3,807,889**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 19,653,113**
HYPOTHETICALS VARIANCE 2			**$ -**	**$ 105,315**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 545,192**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ -	$ 10,672,394	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 10,672,394**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 55,086,243**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 10,385,151	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 10,385,151**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 53,599,397**
HYPOTHETICALS VARIANCE 3			**$ -**	**$ 287,244**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,486,846**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., “with waiver” expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., “without waiver” expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration’s approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus thoroughout the workbook, including the list of active waivers for the demonstration.

Data Entry	Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

‘Data Pulled On:’ - enter the date the source file used to enter data on this tab was pulled
‘For the Time Period Through :’ - enter the date through which the source file data was pulled
Reporting DY' - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter' - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:
- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration.
From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.
Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.
For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.
For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.
In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.
Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Start Date	8/1/1994	8/1/1995	8/1/1996	8/1/1997	9/1/1998	9/1/1999	9/1/2000	9/1/2001	9/1/2002	9/1/2003	9/1/2004	9/1/2005	9/1/2006	9/1/2007	9/1/2008
End Date	7/31/1995	7/31/1996	7/31/1997	7/31/1998	8/31/1999	8/31/2000	8/31/2001	8/31/2002	8/31/2003	8/31/2004	8/31/2005	8/31/2006	8/31/2007	8/31/2008	8/31/2009

DY	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Start Date	9/1/2009	9/1/2010	9/1/2011	9/1/2012	10/1/2013	1/1/2014	1/1/2015	1/1/2016	1/1/2017	1/1/2018	8/1/2019	8/1/2020	8/1/2021	8/1/2022	8/1/2023
End Date	8/31/2010	8/31/2011	8/31/2012	8/31/2013	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	7/31/2019	7/31/2020	7/31/2021	7/31/2022	7/31/2023	7/31/2024

Enter any general comments / notes:

MEG Definitions

	MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
	Medicaid Per Capita								
1	EG 1 - Children		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
2	EG 2 - Adults		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
3	EG 3 - Aged		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
4	EG 4 – Blind/Disabled	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
					N/A				
	Medicaid Per Capita - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Hypothetical 1 Per Capita				Hypothetical Test 1				
1	EG 5 – Group VIII	Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act	N/A	No	Yes	*20*	*10/1/2013*	*20*	*12/31/2013*
			N/A						
			N/A						
	Hypothetical 1 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 2 Per Capita				Hypothetical Test 2				
1	EG 6 - CIS	Expenditures related to the CIS benefits of pre-tenancy supports and tenancy supports; excludes expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 2 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 3 Per Capita				Hypothetical Test 3				
1	EG 7 – CIS Community Transition Pilot	Expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 3 Aggregate								
			N/A						
			N/A						
			N/A						
	Tracking Only								

WOW PMPMs and Aggregates

Medicaid Per Capita		26	27	28	29	30
EG 1 - Children	1	$448.48	$452.96	$457.49	$462.07	$466.69
EG 2 - Adults	2	$925.47	$959.72	$995.23	$1,032.05	$1,070.24
EG 3 - Aged	3	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66
EG 4 – Blind/Disabled	4	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25

Hypothetical 1 Per Capita		26	27	28	29	30
EG 5 – Group VIII	1	$899.37	$942.54	$987.78	$1,035.20	$1,084.89

Hypothetical 2 Per Capita		26	27	28	29	30
EG 6 - CIS	1	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15

Hypothetical 3 Per Capita		26	27	28	29	30
EG 7 – CIS Community Transition Pilot	1	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67

Program Spending Limits

						TOTAL
Program Name and Associated MEGs	**26**	**27**	**28**	**29**	**30**	
Spending Cap						
						$ -
Expenditures Subject to Cap						
Variance						$ -
Over or Under	.	.	.	.	.	.

Date Pulled On: [illegible] Reporting FY: [illegible]

For the Time Period Through: [illegible] Reporting Quarter: [illegible]

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.
1. On the Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two rounds of copy/paste starting from the cell in column A (Waiver Name).
· MAP Waivers/ Total Computable section – into cell A100
· MAP Waivers/ Federal Share section – into cell A200
3. If ADM waivers are applicable to the demonstration, complete two more rounds of copy/paste starting from the cell in column A (Waiver Name).
· ADM Waivers/ Total Computable section – cell A300
· ADM Waivers/ Federal Share section – cell A400

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08
1,115	0	70,981,761	0	0	0	0	0	0	0
1902 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0
1902R2	0	121,392	0	0	0	0	0	0	0
AFDC	0	148,069,654	0	0	0	0	0	0	0
Aged w/Mcare	0	0	0	0	0	0	0	0	0
Aged w/o Mcare	0	0	0	0	0	0	0	0	0
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0
B/D w/Mcare	0	0	0	0	0	0	0	0	0
B/D w/o Mcare	0	0	0	0	0	0	0	0	0
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795
Demo Elig Adults	0	0	0	0	0	0	0	0	134,638
Expansion State Adults	0	0	0	0	0	0	0	0	0
FosterCare(19-20)	0	0	0	0	0	0	0	0	0
HawaiiQuest-1902(R)(2)	0	700,529	107,270	2,484,576	1,636,854	860,335	1,594,466	0	0
HCCP	0	0	0	0	0	0	0	0	0
HealthQuest-Current	0	3,884,748	350,430	12,121,771	10,002,019	7,377,643	10,651,130	9,373,702	64,428,704
HealthQuest-Others	0	1,783,163	215,685	5,322,833	3,698,445	2,678,918	3,915,013	3,306,673	21,010,550
Med Needy Adults	0	0	0	0	0	0	0	0	0
Med Needy Children	0	0	0	0	0	0	0	0	0
MFCP	0	0	0	0	0	0	0	0	0
Newly Eligible Adults	0	0	0	0	0	0	0	0	0
NH w/o W	0	0	0	0	0	0	0	0	0
Opt St Pl Children	0	0	0	0	0	0	0	0	0
Others	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103
OthersX	0	(15,309,727)	0	0	0	0	0	0	0
QUEST ACE	0	0	0	0	0	0	0	0	0
RAACP	0	0	0	0	0	0	0	0	0
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0
State Plan Adults	0	0	0	0	0	0	0	0	(10)
State Plan Children	0	0	0	0	0	0	0	(41)	(9,403)
Supp. - Private	0	0	0	0	0	0	0	0	0
Supp. - State Gov.	0	0	0	0	0	0	0	0	0
UCC-Governmental	0	0	0	0	0	0	0	0	0
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0
UCC-Private	0	0	0	0	0	0	0	0	0
VIII-Like Group	0	0	0	0	0	0	0	0	0
Total	0	1,430,419,192	673,385	19,929,180	15,337,318	10,916,896	18,580,159	228,727,963	244,800,211

Waiver Name	09	10	11	12	13	14	15	16	17	18
1,115	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
1902 R 2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
1902 R 2X	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
1902R2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
AFDC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Aged w/Mcare	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	326,518,117
Aged w/o Mcare	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	19,728,957
Aged with Medicare - MFP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Aged without Medicare - MFP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
B/D w/Mcare	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	77,504,607
B/D w/o Mcare	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	257,028,809
Blind/Disable without Medicare - MFP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Blind/Disabled with Medicare - MFP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Breast Cervical Cancer Treatment (BCCT)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	904,018
CURRENT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
CURRENT POP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Current-Hawaii Quest	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Demo Elig Adults	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	244,752,500
Expansion State Adults	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
FosterCare(19-20)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	73,022
HawaiiQuest-1902(R)(2)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
HCCP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
HealthQuest-Current	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
HealthQuest-Others	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Med Needy Adults	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	8,305
Med Needy Children	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
MFCP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Newly Eligible Adults	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
NH w/o W	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0
Opt St Pl Children	0	0	0	76,678	103,084	80,075	257,166	253,182	31	0
Others	0	0	0	0	0	0	0	0	0	0
Others-Hawaii Quest	0	0	0	0	0	0	0	0	0	0
OthersX	0	0	0	0	0	0	0	0	0	0
QUEST ACE	0	0	0	(2,751)	798,681	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205
RAACP	0	0	0	0	0	7,862,479	17,432,949	0	0	0
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	24,990	2,628,840	2,628,927
State Plan Adults	218	99	39,158	111,982,730	118,021,622	109,034,691	128,225,118	131,863,143	123,596,289	112,790,909
State Plan Children	2,008	878	2,541,467	181,803,051	179,672,723	155,392,585	168,853,209	202,959,370	213,968,923	187,874,968
Supp. - Private	0	0	7,500,002	0	0	0	0	0	0	0
Supp. - State Gov.	0	0	17,822,210	0	0	0	0	0	0	0
UCC-Governmental	0	0	0	15,688,221	22,546,108	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	609,561
UCC-Private	0	0	0	10,056,500	3,403,710	7,500,000	7,500,000	7,500,000	7,500,000	0
VIII-Like Group	0	0	0	0	0	0	0	0	0	0
Total	294,243,934	368,276,721	514,860,384	444,696,938	454,123,543	464,250,373	785,020,500	1,211,765,023	1,357,369,890	1,307,250,747

Waiver Name	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	0	0	0	0	0	0	0	0	0	0	0	70,981,761	70,981,761
1902 R 2	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R 2X	0	0	0	0	0	0	0	0	0	0	0	0	(8,243,749)	(8,243,749)
1902R2	0	0	0	0	0	0	0	0	0	0	0	0	121,392	121,392
AFDC	0	0	0	0	0	0	0	0	0	0	0	0	148,069,654	148,069,654
Aged w/Mcare	349,156,948	184,750,729	364,919,444	307,865,937	320,856,325	332,285,621	556,431,345	364,714,483	64,039,696	0	0	0	3,958,485,089	3,958,485,089
Aged w/o Mcare	24,483,589	14,925,306	37,994,811	48,712,106	46,535,285	55,786,925	84,337,947	64,326,264	12,051,993	0	0	0	453,777,281	453,777,281
Aged with Medicare - MFP	0	0	0	(473,188)	(505,165)	(397,775)	(598,936)	(474,228)	0	0	0	0	(2,449,292)	(2,449,292)
Aged without Medicare - MFP	0	0	0	(14,668)	(44,822)	(62,495)	(43,976)	(17,253)	0	0	0	0	(183,214)	(183,214)
B/D w/Mcare	88,201,319	49,105,356	98,847,286	163,362,887	158,584,686	155,598,645	244,914,264	147,887,636	25,827,781	0	0	0	1,397,465,261	1,397,465,261
B/D w/o Mcare	282,670,355	148,440,400	290,201,067	285,336,958	310,399,367	342,048,447	473,294,409	336,314,844	61,962,769	0	0	0	3,329,537,263	3,329,537,263
Blind/Disable without Medicare - MFP	0	0	0	(324,738)	(333,645)	(370,635)	(399,762)	(285,331)	0	0	0	0	(1,714,111)	(1,714,111)
Blind/Disabled with Medicare - MFP	0	0	0	(61,110)	(74,223)	(153,925)	(230,511)	(80,659)	0	0	0	0	(600,428)	(600,428)
Breast Cervical Cancer Treatment (BCCT)	750,145	365,104	585,589	277,616	222,869	103,847	107,788	52,983	15,411	0	0	0	3,934,753	3,934,753
CURRENT	0	0	0	0	0	0	0	0	0	0	0	0	730,733,483	730,733,483
CURRENT POP	0	0	0	0	0	0	0	0	0	0	0	0	272,778,438	272,778,438
Current-Hawaii Quest	0	0	0	0	0	0	0	0	0	0	0	0	40,064,795	40,064,795
Demo Elig Adults	227,394,155	43,950,943	55,913	(5,724)	735	0	0	0	0	0	0	0	1,546,271,707	1,546,271,707
Expansion State Adults	0	0	191,925,290	343,651,347	477,526,936	546,471,295	785,972,863	533,568,145	102,364,785	0	0	0	2,981,480,661	2,981,480,661
FosterCare(19-20)	176,324	173,482	703,614	618,274	885,664	1,318,600	2,269,310	1,688,771	301,633	0	0	0	8,615,120	8,615,120
HawaiiQuest-1902(R)(2)	0	0	0	0	0	0	0	0	0	0	0	0	7,925,126	7,925,126
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	818,679	818,679
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	1,007,884,906	1,007,884,906
HealthQuest-Others	0	0	0	0	0	0	0	0	0	0	0	0	297,918,759	297,918,759
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	1,331	217,050,612	165,225,916	110,172,746	129,039,016	188,021,506	115,986,324	21,506,059	0	0	0	947,003,510	947,003,510
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	770,216	770,216
Others	0	0	0	0	0	0	0	0	0	0	0	0	376,237,032	376,237,032
Others-Hawaii Quest	0	0	0	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	0	0	0	0	0	0	0	0	0	0	0	0	(15,309,727)	(15,309,727)
QUEST ACE	76,432,838	26,173,447	106,232	0	0	0	0	0	0	0	0	0	205,854,785	205,854,785
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Immig/COFAs	2,873,646	987,921	1,532,329	1,448,764	2,048,646	2,315,023	4,043,498	3,065,981	430,430	0	0	0	24,028,995	24,028,995
State Plan Adults	130,112,852	80,834,554	202,368,440	172,913,238	169,042,108	182,900,835	252,985,641	164,588,606	31,863,396	0	0	0	2,223,163,637	2,223,163,637
State Plan Children	215,942,758	106,595,650	248,572,791	306,184,516	316,589,798	372,772,425	583,608,263	380,433,440	65,598,485	0	0	0	3,889,357,864	3,889,357,864
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	0	7,500,002	7,500,002
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	12,164,879	5,856,911	10,090,466	6,184,588	981,179	0	0	0	0	0	0	0	216,220,054	216,220,054
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	38,818,619	39,694,442	82,153,936	85,515,739	66,000,000	0	0	0	0	0	0	0	355,642,946	355,642,946
VIII-Like Group	0	71,468,225	(8,863)	0	0	0	0	0	0	0	0	0	71,459,362	71,459,362
Total	1,449,178,427	773,323,801	1,747,098,957	1,886,418,458	1,978,888,489	2,119,655,849	3,174,713,649	2,111,770,006	385,962,438	0	0	0	24,798,252,431	24,798,252,431

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08
1,115	0	35,490,882	0	0	0	0	0	0	0
1902 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0
1902R2	0	60,696	0	0	0	0	0	0	0
AFDC	0	74,034,827	0	0	0	0	0	0	0
Aged w/Mcare	0	0	0	0	0	0	0	0	0
Aged w/o Mcare	0	0	0	0	0	0	0	0	0
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0
B/D w/Mcare	0	0	0	0	0	0	0	0	0
B/D w/o Mcare	0	0	0	0	0	0	0	0	0
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0
CURRENT	0	247,684,665	0	0	0	0	904,176	83,526,544	40,668,142
CURRENT POP	0	136,389,220	0	0	0	0	0	0	0
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505
Demo Elig Adults	0	0	0	0	0	0	0	0	79,127
Expansion State Adults	0	0	0	0	0	0	0	0	0
FosterCare(19-20)	0	0	0	0	0	0	0	0	0
HawaiiQuest-1902(R)(2)	0	353,988	53,702	1,242,907	818,930	430,573	808,769	0	0
HCCP	0	0	0	0	0	0	0	0	0
HealthQuest-Current	0	1,963,002	175,736	6,063,866	5,004,058	3,692,366	5,386,340	4,903,637	36,087,606
HealthQuest-Others	0	901,053	107,974	2,662,739	1,849,641	1,340,727	1,981,352	1,733,011	11,768,154
Med Needy Adults	0	0	0	0	0	0	0	0	0
Med Needy Children	0	0	0	0	0	0	0	0	0
MFCP	0	0	0	0	0	0	0	0	0
Newly Eligible Adults	0	0	0	0	0	0	0	0	0
NH w/o W	0	0	0	0	0	0	0	0	0
Opt St Pl Children	0	0	0	0	0	0	0	0	0
Others	0	144,525,295	0	0	0	0	426,612	29,580,209	16,428,385
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260
OthersX	0	(7,809,492)	0	0	0	0	0	0	0
QUEST ACE	0	0	0	0	0	0	0	0	0
RAACP	0	0	0	0	0	0	0	0	0
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0
State Plan Adults	0	0	0	0	0	0	0	0	(6)
State Plan Children	0	0	0	0	0	0	0	(23)	(5,530)
Supp. - Private	0	0	0	0	0	0	0	0	0
Supp. - State Gov.	0	0	0	0	0	0	0	0	0
UCC-Governmental	0	0	0	0	0	0	0	0	0
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0
UCC-Private	0	0	0	0	0	0	0	0	0
VIII-Like Group	0	0	0	0	0	0	0	0	0
Total	0	716,158,823	337,412	9,969,512	7,672,629	5,463,666	9,493,195	119,743,378	135,002,643

Waiver Name	09	10	11	12	13	14	15	16	17	18
1,115	0	0	0	0	0	0	0	0	0	0
1902 R 2	0	0	0	0	0	0	0	0	0	0
1902 R 2X	0	0	0	0	0	0	0	0	0	0
1902R2	0	0	0	0	0	0	0	0	0	0
AFDC	0	0	0	0	0	0	0	0	0	0
Aged w/Mcare	0	0	0	0	0	(199)	81,134,508	211,362,743	229,319,379	165,433,841
Aged w/o Mcare	0	0	0	0	0	0	1,622,988	11,822,762	16,022,396	9,984,628
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0
B/D w/Mcare	0	0	0	0	0	(9,251)	21,277,328	49,857,636	52,547,252	39,129,038
B/D w/o Mcare	0	0	0	0	0	(19,525)	54,511,233	141,799,152	161,274,589	130,207,936
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	(1)	2,754	361,286	592,247
CURRENT	0	0	0	0	0	0	0	0	0	0
CURRENT POP	0	0	0	0	0	0	0	0	0	0
Current-Hawaii Quest	0	0	0	0	0	0	0	0	0	0
Demo Elig Adults	1,144	30,236	186,922	75,196,276	74,766,107	87,642,204	114,378,784	135,452,513	154,819,222	123,131,091
Expansion State Adults	0	0	0	0	0	0	0	0	0	0
FosterCare(19-20)	0	0	0	0	0	51,916	53,413	63,415	89,013	36,291
HawaiiQuest-1902(R)(2)	166	20,369	256,468	0	0	18,679	19,755	5,389	0	0
HCCP	0	0	0	0	0	76,578	438,797	0	0	0
HealthQuest-Current	132,768,282	165,985,082	231,578,381	(1,365,848)	0	0	0	0	0	0
HealthQuest-Others	36,642,802	60,584,431	55,313,761	(363,962)	0	0	0	0	0	0
Med Needy Adults	0	0	0	32,497	68,553	68,082	38,985	78,049	64,590	4,238
Med Needy Children	0	0	0	0	0	0	5,196	2,666	0	0
MFCP	0	0	0	0	0	69,404	368,050	0	0	0
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0
NH w/o W	0	0	0	0	0	2,881,647	10,235,011	0	0	0
Opt St Pl Children	0	0	0	44,819	59,404	45,487	166,217	170,408	21	0
Others	0	0	0	0	0	0	0	0	0	0
Others-Hawaii Quest	0	0	0	0	0	0	0	0	0	0
OthersX	0	0	0	0	0	0	0	0	0	0
QUEST ACE	0	0	0	(1,583)	454,606	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685
RAACP	0	0	0	0	0	4,442,944	10,922,768	0	0	0
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	16,829	1,707,938	1,317,977
State Plan Adults	125	52	22,986	65,812,117	68,288,552	61,892,816	82,540,889	88,651,957	80,730,594	56,365,779
State Plan Children	1,173	507	1,494,521	106,725,591	103,797,242	88,086,005	108,850,847	136,539,237	138,140,612	92,677,457
Supp. - Private	0	0	4,385,251	0	0	0	0	0	0	0
Supp. - State Gov.	0	0	10,614,749	0	0	0	0	0	0	0
UCC-Governmental	0	0	0	9,212,484	13,041,165	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	307,706
UCC-Private	0	0	0	5,787,516	1,958,835	4,237,500	4,959,750	5,051,250	4,697,250	0
VIII-Like Group	0	0	0	0	0	0	0	0	0	0
Total	169,413,692	226,620,677	303,853,039	261,079,907	262,434,464	263,479,344	510,938,536	813,433,104	881,694,769	657,883,831

Waiver Name	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	0	0	0	0	0	0	0	0	0	0	0	35,490,882	35,490,882
1902 R 2	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R 2X	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	0	0	0	0	0	0	0	0	0	0	0	0	74,034,827	74,034,827
Aged w/Mcare	179,767,116	95,671,244	189,594,082	162,182,080	173,947,428	182,375,956	302,237,727	208,697,277	38,212,487	0	0	0	2,219,935,669	2,219,935,669
Aged w/o Mcare	12,621,590	7,728,650	19,714,969	25,630,796	25,194,791	30,581,769	45,665,494	36,921,822	7,191,424	0	0	0	250,704,079	250,704,079
Aged with Medicare - MFP	0	0	0	(249,679)	(273,613)	(218,333)	(324,766)	(268,101)	0	0	0	0	(1,334,492)	(1,334,492)
Aged without Medicare - MFP	0	0	0	(7,720)	(24,377)	(34,310)	(23,817)	(9,392)	0	0	0	0	(99,616)	(99,616)
B/D w/Mcare	45,400,574	25,392,157	51,341,230	86,036,126	85,942,520	85,381,721	133,031,444	84,577,239	15,411,437	0	0	0	775,316,451	775,316,451
B/D w/o Mcare	145,622,789	76,872,883	150,336,282	149,646,906	167,640,879	187,306,580	255,487,844	192,322,407	36,973,186	0	0	0	1,849,983,141	1,849,983,141
Blind/Disable without Medicare - MFP	0	0	0	(171,495)	(180,813)	(203,447)	(216,481)	(160,969)	0	0	0	0	(933,205)	(933,205)
Blind/Disabled with Medicare - MFP	0	0	0	(32,236)	(40,358)	(84,504)	(125,175)	(45,312)	0	0	0	0	(327,585)	(327,585)
Breast Cervical Cancer Treatment (BCCT)	495,478	241,945	376,275	201,477	152,695	77,771	62,593	34,490	9,196	0	0	0	2,608,206	2,608,206
CURRENT	0	0	0	0	0	0	0	0	0	0	0	0	372,783,527	372,783,527
CURRENT POP	0	0	0	0	0	0	0	0	0	0	0	0	136,389,220	136,389,220
Current-Hawaii Quest	0	0	0	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	116,746,726	22,522,276	29,051	(3,183)	397	0	0	0	0	0	0	0	904,978,893	904,978,893
Expansion State Adults	0	0	157,575,707	316,564,065	458,125,253	506,885,661	730,096,646	485,962,666	92,128,307	0	0	0	2,747,338,305	2,747,338,305
FosterCare(19-20)	90,804	89,632	365,633	326,044	480,663	723,548	1,231,959	966,284	179,985	0	0	0	4,748,600	4,748,600
HawaiiQuest-1902(R)(2)	0	0	0	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	1,331	217,032,614	165,225,680	110,132,233	122,629,623	176,007,124	105,676,213	19,355,453	0	0	0	916,060,271	916,060,271
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	486,356	486,356
Others	0	0	0	0	0	0	0	0	0	0	0	0	190,960,501	190,960,501
Others-Hawaii Quest	0	0	0	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	0	0	0	0	0	0	0	0	0	0	0	0	(7,809,492)	(7,809,492)
QUEST ACE	39,331,445	13,397,540	55,183	0	0	0	0	0	0	0	0	0	115,390,826	115,390,826
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St Pl Adults-Preg Immig/COFAs	1,473,988	508,843	795,526	764,288	1,111,786	1,270,634	2,194,658	1,756,344	256,838	0	0	0	13,175,649	13,175,649
State Plan Adults	66,741,085	41,647,599	104,845,589	90,882,653	91,217,054	100,249,540	136,997,743	94,158,843	19,012,889	0	0	0	1,250,058,856	1,250,058,856
State Plan Children	110,463,464	54,513,194	128,939,345	161,395,719	171,534,913	204,479,908	316,700,343	217,875,713	39,142,615	0	0	0	2,181,352,853	2,181,352,853
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	0	4,385,251	4,385,251
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	6,249,536	3,037,111	5,240,639	3,261,810	529,641	0	0	0	0	0	0	0	125,000,399	125,000,399
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	20,131,336	20,583,506	42,677,271	45,049,870	35,626,800	0	0	0	0	0	0	0	190,760,884	190,760,884
VIII-Like Group	0	37,060,184	(4,595)	0	0	0	0	0	0	0	0	0	37,055,589	37,055,589
Total	745,135,931	399,268,095	1,068,914,801	1,206,703,201	1,321,117,892	1,421,422,117	2,099,023,336	1,428,465,524	267,873,817	0	0	0	15,312,597,335	15,312,597,335

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	63,695,860	0	0	0	0	1,013,990,557	1,013,990,557
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214	12,833,291	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	40,068,477	45,961,643	56,826,439	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	63,695,860	0	0	0	0	1,061,954,810	1,061,954,810

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	16,364,026	0	0	0	733,753,927	733,753,927
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187	6,534,554	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	21,285,217	23,906,078	31,788,472	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	16,364,026	0	0	0	758,450,542	758,450,542

C Report Grouper

MAP Waivers Only

Total Computable

MEG Names		**C Report Waiver Names**	**26**	**27**	**28**	**29**	**30**
Medicaid Per Capita							
EG 1 - Children	1	FosterCare(19-20)	$1,688,771	$301,633			
EG 1 - Children	1	State Plan Children	$380,433,440	$65,598,485			
EG 2 - Adults	2	State Plan Adults	$164,588,606	$31,863,396			
EG 2 - Adults	2	Breast Cervical Cancer Treatment (BCCT)	$52,983	$15,411			
EG 2 - Adults	2	St Pl Adults-Preg Immig/COFAs	$3,065,981	$430,430			
EG 3 - Aged	3	Aged w/Mcare	$364,714,483	$64,039,696			
EG 3 - Aged	3	Aged w/o Mcare	$64,326,264	$12,051,993			
EG 3 - Aged	3	Aged with Medicare - MFP	($474,228)				
EG 3 - Aged	3	Aged without Medicare - MFP	($17,253)				
EG 4 – Blind/Disabled	4	B/D w/Mcare	$147,887,636	$25,827,781			
EG 4 – Blind/Disabled	4	B/D w/o Mcare	$336,314,844	$61,962,769			
EG 4 – Blind/Disabled	4	Blind/Disable without Medicare - MFP	($285,331)				
EG 4 – Blind/Disabled	4	Blind/Disabled with Medicare - MFP	($80,659)				
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1	VIII-Like Group					
EG 5 – Group VIII	1	Expansion State Adults	$533,568,145	$102,364,785			
EG 5 – Group VIII	1	Newly Eligible Adults	$115,986,324	$21,506,059			
Hypothetical 2 Per Capita							
EG 6 - CIS	1	EG 6 - CIS					
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1	EG 7 – CIS Community Transition Pilot					
TOTAL			$2,111,770,006	$385,962,438			

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.
Positive adjustments increase expenditures, and negative adjustments decrease expenditures.
Enter adjustments for every MEG for which adjustments were made or are planned.
Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -$10,000 reflects a decrease in expenditures).

		26	27	28	29	30	Description (type of collection, time period, CMS-64 reporting line, etc.)
Medicaid Per Capita							
EG 1 - Children	1						
EG 2 - Adults	2						
EG 3 - Aged	3	-$41,869,720					Cost share
EG 4 – Blind/Disabled	4	-$4,076,809					Cost share
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1						
Hypothetical 2 Per Capita							
EG 6 - CIS	1						
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1						

WW Spending - Actual

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$382,122,211	$65,900,118			
EG 2 - Adults	2	$167,707,570	$32,309,237			
EG 3 - Aged	3	$386,679,546	$76,091,689			
EG 4 – Blind/Disabled	4	$479,759,681	$87,790,550			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$649,554,469	$123,870,844			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					
TOTAL		**$ 2,065,823,477**	**$ 385,962,438**	**$ -**	**$ -**	**$ -**

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.
Enter the projected annual expenditures for each DY per MEG for the active DYs.
For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1		$337,253,185	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2		$186,094,530	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3		$365,302,965	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4		$496,741,303	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		$702,119,454	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$3,807,889	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$10,385,151	$13,386,875	$14,380,181	$15,447,190

WW Spending - Total

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$382,122,211	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$167,707,570	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$386,679,546	$441,394,654	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$479,759,681	$584,531,853	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$649,554,469	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$3,807,889	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$10,385,151	$13,386,875	$14,380,181	$15,447,190
TOTAL		**$ 2,065,823,477**	**$ 2,487,666,914**	**$ 2,632,405,315**	**$ 2,782,912,389**	**$ 2,942,576,003**

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.
For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.
Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.
Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1402624	242327			
EG 2 - Adults	2	420331	74104			
EG 3 - Aged	3	339459	58899			
EG 4 – Blind/Disabled	4	285411	48569			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1411914	261768			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					

Member Months - Projected

Enter/adjust projected member months based on reported actuals.
Enter projected number of member months for each active DY per MEG for the demonstration.
For the current DY, enter only the number that reflects projections for future quarters of the DY.
Do not include member months for either the current reporting quarter or past quarters.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1		1342447	1624394	1665004	1706629
EG 2 - Adults	2		440289	527253	540435	553945
EG 3 - Aged	3		273944	336172	339533	342929
EG 4 – Blind/Disabled	4		270725	322487	325712	328969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		1301492	1602341	1642400	1683460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		3152	3877	3974	4073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		3152	3877	3974	4073

Member Months - Total

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629
EG 2 - Adults	2	420,331	514,393	527,253	540,435	553,945
EG 3 - Aged	3	339,459	332,843	336,172	339,533	342,929
EG 4 – Blind/Disabled	4	285,411	319,294	322,487	325,712	328,969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		3,152	3,877	3,974	4,073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		3,152	3,877	3,974	4,073

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	26
Budget Neutrality Reporting End DY	30

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	420,331	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	339,459	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	285,411	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,431,735,669**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,307,865,902**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 382,122,211	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,531,974,433
EG 2 - Adults	2		$ 167,707,570	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,178,405,101
EG 3 - Aged	3		$ 386,679,546	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,178,185,372
EG 4 – Blind/Disabled	4		$ 479,759,681	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,168,903,373
TOTAL			**$ 1,416,269,008**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,498,357,192**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 382,122,211	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 246,926,601	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 185,194,950	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 167,707,570	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 221,296,161	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 165,972,120	$ 206,452,113	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 386,679,546	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 271,589,163	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 203,691,873	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 479,759,681	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 275,654,737	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 206,741,053	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 761,599,996**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,357,131,533**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 253,866,665**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,452,377,178**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,452,377,178**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,670,135,673	$ 3,596,043,074	$ 5,614,959,229	$ 7,731,553,088	$ 9,950,734,370	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,402,713	$ 53,940,646	$ 56,149,592	$ 38,657,765	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (253,866,665)	$ (532,290,490)	$ (824,375,504)	$ (1,130,824,751)	$ (1,452,377,178)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,269,833,094	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,269,833,094**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,852,609,967**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$649,554,469	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 649,554,469**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,339,774,396**

HYPOTHETICALS VARIANCE 1			**$ 620,278,625**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,512,835,571**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 3,913,204	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 3,913,204**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 20,198,305**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 3,807,889	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 3,807,889**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 19,653,113**

HYPOTHETICALS VARIANCE 2			**$ -**	**$ 105,315**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 545,192**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ -	$ 10,672,394	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 10,672,394**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 55,086,243**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 10,385,151	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 10,385,151**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 53,599,397**

HYPOTHETICALS VARIANCE 3			**$ -**	**$ 287,244**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,486,846**

Yes No
Yes
No

Per Capita or Aggregate
Per Capita
Aggregate

Phase-Down
No Phase-Down
Savings Phase-Down

Actuals and Projected
Actuals Only
Actuals + Projected

MAP_ADM
MAP+ADM Waivers
MAP Waivers Only

Waiver List
MAP WAIVERS
Not Applicable
1,115
1902 R 2
1902 R 2X
1902R2
AFDC
Aged w/Mcare
Aged w/o Mcare
Aged with Medicare - MFP
Aged without Medicare - MFP
B/D w/Mcare
B/D w/o Mcare
Blind/Disable without Medicare - MFP
Blind/Disabled with Medicare - MFP
Breast Cervical Cancer Treatment (BCCT)
CURRENT
CURRENT POP
Current-Hawaii Quest
Demo Elig Adults
EG 6 - CIS
EG 7 – CIS Community Transition Pilot
Expansion State Adults
FosterCare(19-20)
HawaiiQuest-1902(R)(2)
HCCP
HealthQuest-Current
HealthQuest-Others
Med Needy Adults
Med Needy Children
MFCP
Newly Eligible Adults
NH w/o W
Opt St Pl Children
Others
Others-Hawaii Quest
OthersX
QUEST ACE
RAACP
St PI Adults-Preg Immig/COFAs
State Plan Adults
State Plan Children
Supp. - Private
Supp. - State Gov.
UCC-Governmental
UCC-GOVT LTC
UCC-Private
VIII-Like Group
ADM WAIVERS

Demonstration Reporting Start DY	26
Demonstration Reporting End DY	30

Reporting Net Variance
$ 1,452,377,178

2018 – 2019 Hawaii MQD Health Plan Initiatives for 2020 CMS Annual Report

Assessment of Follow-Up to Prior Year Recommendation

2019 Assessment of Follow-Up to Prior Year Recommendations

This is an assessment of how effectively the QUEST Integration health plans addressed the improvement recommendations made by HSAG in the prior year (2018) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The CCS program members were not separately sampled for the CAHPS survey as they were included in the QI health plans' sampling; therefore, there are not separate CAHPS results related to CCS members.

Except for the compliance monitoring section and PIPs, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to identify the degree to which the health plans' initiatives were responsive to the improvement opportunities. Plan responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2017 compliance reviews were carried over to 2018. The specific compliance review findings and recommendations were reported in the 2017 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance. Four QI health plans and 'Ohana CCS were found to have sufficiently addressed and corrected their findings of deficiencies through implementation of CAPs and were found to be in full compliance with requirements during the reevaluations conducted by HSAG in 2018. KFHP QI completed its remaining CAP items in March 2019.

Performance Improvement Projects

In alignment with the rapid-cycle PIP process, recommendations are made at the submission of each PIP module. The health plans addressed the recommendations as part of either the resubmission of the module or the submission of the next module. Therefore, the 2018 technical report did not contain specific recommendations. All health plans worked with HSAG to implement recommended improvements to subsequent PIP submissions.

AlohaCare Quest Integration (AlohaCare QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

Based on AlohaCare QI's data systems and processes, the auditors made some recommendations:

- Regarding the integration of behavioral health data from 'Ohana CCS, HSAG recommends that the data be integrated for data reporting to ensure accuracy of reporting on services received by members.
- HSAG recommends that AlohaCare QI improve oversight to ensure all state-required measures are included in the list provided to its vendors responsible for measure calculation, hybrid sample selection, and other medical record review related tasks. AlohaCare QI should proactively trend to anticipate

exclusion counts and ensure that the selected oversample will accommodate for required exclusions and valid data errors.

Improvement Activities Implemented

Regarding the integration of behavioral health data from ‘Ohana CCS, AlohaCare established a process whereby the claims and encounter data are received quarterly. These data are processed through our certified HEDIS vendor, Inovalon, through interfaces designed in Inovalon’s systems, as well as our internal reporting queries. This allows for ongoing evaluation and monitoring of any related metrics as a part of standard reporting tools. Additionally, AlohaCare expects that reporting of behavioral health related metrics will improve for the next reporting period.

AlohaCare has been working with Inovalon and our corporate HEDIS auditor (Advent Advisory Group) on HEDIS throughout the summer to prepare for the next HEDIS season and to ensure accurate and timely delivery of tasks such as measure calculation, hybrid sample selection, and other medical record review related tasks. The early intervention of our HEDIS schedule also includes monthly proactive rate trending to anticipate exclusion counts and evaluation of oversample populations. Additionally, AlohaCare staff will attend Advent Advisory Group’s HEDIS conference to receive training on changes in HEDIS 2020 requirements and identify opportunities for efficiencies. AlohaCare will continue to use internal reporting for Hawaii State measures *Emergency Department Visits for Ambulatory Care Sensitive Condition (NYU) and Follow-Up With a Primary Care Practitioner (PCP) After Hospitalization for Mental Illness (FUP)*.

2018 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of AlohaCare QI’s 56 measure rates comparable to benchmarks, 17 measure rates (30.4 percent) ranked at or above the national Medicaid 50th percentile, with six of these rates (10.7 percent) above the 75th percentile, indicating positive performance regarding access to care and well-child visits for young children, weight assessment and counseling for children and adolescents, medication management for members with asthma, and low ED utilization. Additionally, AlohaCare QI met one of the MQD Quality Strategy targets for HEDIS 2018 (*Medication Management for People With Asthma—Medication Compliance 75%—Total*).

Conversely, 39 of AlohaCare QI’s measure rates that were comparable to national benchmarks (69.6 percent) ranked below the national Medicaid 50th percentile, with 32 of these rates (57.1 percent) below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

• Access to Care

– *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, 65 Years and Older, and Total*

– *Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*

• Children’s Preventive Health

– Childhood Immunization Status—Combination 3, DTaP, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, and VZV

– Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap

• Women's Health

– Cervical Cancer Screening

– Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total

– Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care

• Care for Chronic Conditions

– Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Medical Attention for Nephropathy

• Behavioral Health

– Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

– Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

– Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up

Improvement Activities Implemented

The plan identified several barriers to improved HEDIS performance in reporting year 2017 and in response, implemented several interventions throughout 2018. The aggregate success of these interventions did make a positive impact on HEDIS measure rates, but the plan does recognize that 39 measures still rank below the 50th percentile, with 32 of these measures ranking below the 25th percentile. Overall the planned improvement activities included the continued progress of several of the interventions implemented in 2018 as well as the evaluation of additional interventions.

Continued Interventions

Pay for Performance Program (P4P): AlohaCare will continue to evaluate and improve the structure, administration, and participation of the P4P program to maximize effectiveness. The P4P program will be diligently communicated to network providers and will be supported through routine coordinated meetings by Quality Improvement staff to provide education and feedback on performance.

Quality Improvement Department Structure: The infrastructure changes to the Quality Improvement department were completed in 2018 with the establishment of the Quality Improvement Teams (QITs). The QITs were established to analyze results and determine barriers, as well as to recommend actions to be taken by the member- or provider-facing teams and other AlohaCare functional departments. The membership on QITs is cross-functional. QITs use rapid-cycle improvement and are not meant to be long-term assignments. All QI staff were given a performance goal of actively participating in at least one QIT.

Additionally, a provider-facing team was established in 2018 and is managed by the QI performance accountability manager and includes a team of QI review nurses to coach the Community Health Centers and PCPs with panels of 50 members or greater. The focus of this team is to furnish training and feedback regarding closing gaps in care, use of the Health Catalyst reports to target members for outreach, and encourage participation in the P4P incentive program. This team has strict performance expectations and have both face-to-face and telephonic meetings on all the islands.

Gaps in Care (GIC) Lists: The plan successfully implemented and rolled out the use of GIC lists in September 2018. The GIC data are produced from the newly implemented data warehouse, Health Catalyst. The QI nurses on the provider-facing team are now meeting in person or by telephone with all PCPs who have panels of greater than 50 members to deliver and encourage use of the GIC reports. Providers are requesting the ability to see their own compliance in a scorecard format and allow for the comparison to performance of peers. This is the next phase of the intervention which is planned for Q4 2019.

New Model of Care & Care Coordination: The plan implemented a new model of care in 2018 with a focus on:

• Integration of care across Medicare and Medicaid (80 percent of special needs plan [SNP] members are dually enrolled in AlohaCare QI).

• Addressing long-term service needs in addition to acute care needs.

• Coordination of needs across physical, behavioral, and social health services including addressing the impact of social determinants of health (SDoH).

• Proactive identification of members at risk for future healthcare episodes and coordination of preventive interventions.

In early 2019, a focus on gaps in care specific to HEDIS and other preventive care measures was added to the model of care. The next phase of this intervention is the integration of GIC data from Health Catalyst into the new case management and medical records system, Guiding Care (G8).

Digital Outreach Campaigns: In 2018 the Population Health—Quality Improvement Department contracted with HealthCrowd to implement a digital outreach program with the Unified Communications Platform. The platform coordinated the use of multiple digital modalities including SMS text and multiple-level interactive voice response (IVR) phone calls, depending on the modality that is most appropriate and works best for each member. The focus for 2018 campaigns included:

• Well-care visits for children and adolescents

• Childhood immunizations

• Prenatal and postpartum care

• Diabetes care

The plan will continue to evaluate the effectiveness of this intervention and will evaluate the potential use for additional measures.

Potential Additional Interventions

Member Wellness Programs and Incentives: The plan will evaluate the use of programs designed to promote preventive services through incentives. The plan is currently evaluating evidence-based programs with proven effectiveness.

Community/Home-Based Practitioner Visits: The plan will evaluate the use of mobile practitioners, including physicians and nurse practitioners, to visit members in the community setting. This intervention will improve access to preventive services when access is a barrier. Additionally, this intervention will be evaluated to close gaps in care in the homeless population.

CAHPS—Adult Survey

2018 Recommendations

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Care Quickly, Getting Needed Care, and Coordination of Care*.

Improvement Activities Implemented

In accordance with the AlohaCare QAPI Program and workplan, the CAHPS survey outcomes were presented to the Corporate Quality Improvement Committee (CQIC) in June 2019. During that presentation, the CAHPS Survey evaluation also identified *Getting Care Quickly, Getting Needed Care* and *Coordination of Care* as potential areas of quality improvement and recommended the following:

1. Obtain a current population based on the DSS survey methodology by July 31, 2019.

2. Use this population to determine the following sub-populations by July 31, 2019:

a. Members with primary care visits

b. Members with specialist visits

i. Number of specialist visits

ii. Specialists

c. Members with an assigned care coordinator or service coordinator d. Members with authorizations for services

3. Using the population, conduct mini-surveys through outreach to determine satisfaction with related processes and identify potential issues by October 31, 2019.

4. Report findings and determine any opportunities for improvement to the following CQIC meeting.

Additionally, individuals representing oversight for Quality Improvement, Provider Services, Utilization Management, and Care Coordination were assigned to identify potential areas for improvement and report back to CQIC. The CQIC will continue to monitor the progress of the interventions and any identified opportunities.

Provider Survey

2018 Recommendations

Based on the survey results, AlohaCare QI should focus efforts on improving the following three measures which scored statistically significantly lower than the QI Program aggregate:

• *Adequate Access to Non-Formulary Drugs*

• *Adequacy of Specialists*

• *Adequacy of Behavioral Health Specialists*

Improvement Activities Implemented

The outcomes of the Provider Survey were presented to the CQIC in August. Recommendations were made by the CQIC to evaluate and develop activities to improve any measure rate that was lower than the QI Program aggregate in the plan comparison.

Activities to improve provider satisfaction with access to non-formulary drugs: The Clinical Pharmacy Department monitors prior authorization (PA) requests for PA required and non-formulary agents quarterly as part of the functions of the Pharmacy and Therapeutics (P&T) Committee meeting. For drugs with a high percentage of approval, the plan will either add these drugs to the formulary or require a step therapy to alleviate the unnecessary PA request by providers. Quarterly, the Clinical Pharmacy Department will assess its PA program to ensure appropriate access to therapy. Medications that have a high approval rate are evaluated for potential addition to the formulary.

Activities to improve provider satisfaction with adequacy of specialists: The Provider Network department monitors physician-to-member ratios, geo-access time and distance, and provider counts for each specialty by island for compliance with reporting to Hawaii DHS, and for internal network development planning. For communities on each island where AlohaCare does not have a contracted local provider in a given specialty, or there is a lack of choice of providers in that specialty, AlohaCare will contact and offer contracts to specialists practicing in the community that are not currently participating in network with AlohaCare. Good faith efforts to contract will be documented in the Network Development tracking tool, with the result (e.g., contract executed, provider declined) also documented. If there are no providers of a given specialty practicing in that community, AlohaCare will document the absence of availability for that specialty and document our process for arranging for services in that specialty (e.g., travel arrangements for members to the nearest contracted or out-of-network provider in that specialty; arrange for contracted specialists from another community or island to travel to the community with an absence of that specialty; or in some circumstances, provide telemedicine access to that specialty). AlohaCare will ensure that PCPs are aware of what specialists are participating in our network by distributing a current listing of our specialty network through multiple communication methods (e.g., fax, email, provider website, newsletter, and site visits to primary care offices). These communications will also describe how PCPs can obtain assistance from AlohaCare in locating a given specialist when they need to refer members for specialty care.

Activities to improve provider satisfaction with adequacy of behavioral health specialists: The Provider Network department monitors behavioral health provider-to member ratios, geo-access time and distance, and behavioral health provider counts for each behavioral health specialty by island for compliance with reporting to Hawaii DHS, and for internal Network Development planning. For communities on each island where AlohaCare does not have a contracted local behavioral health specialist, or there is a lack of choice of behavioral health specialists, AlohaCare will contact and offer

contracts to behavioral health specialists practicing in the community that are not currently participating in network with AlohaCare. Good faith efforts to contract will be documented in the Network Development tracking tool, with the result (e.g., contract executed, provider declined) also documented. If there are no behavioral health specialists practicing in that community, AlohaCare will document the absence of availability and document our process for arranging for these services (e.g., travel arrangements for members to the nearest contracted or out-of-network provider; arrange for contracted behavioral health specialists from another community or island to travel to the community with an absence of behavioral health specialists; or in some circumstances, provide telemedicine access for specialty behavioral health). AlohaCare will ensure that PCPs are aware of what behavioral health specialists are participating in our network by distributing a current listing of our behavioral health specialists through multiple communication methods (e.g., fax, email, provider website, newsletter, and site visits to primary care offices). These communications will also describe how PCPs can obtain assistance from AlohaCare in locating a behavioral health specialist when they need to refer members for specialty behavioral health services.

HMSA Quest Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

Based on HMSA QI's data systems and processes, the auditors made one recommendation:

• HSAG recommended that HMSA QI improve oversight to ensure all state-required measures are included in the list provided to its vendors responsible for measure calculation, hybrid sample selection, and other tasks related to medical record review. HMSA QI should proactively anticipate exclusion counts and ensure that the selected oversample will accommodate for required exclusions and valid data errors.

Improvement Activities Implemented

The HEDIS 2018 Compliance Audit recommendation was based on the CDC HbA1c Control <7% minimum required sample size (MRSS) not being met because the oversample was not large enough to cover the amount of required exclusions removed from the hybrid sample.

To address the audit recommendation, HMSA QI modified its process to evaluate the number of exclusions and oversamples after each administrative data refresh and medical record review portable database synchronization. Previously, the evaluation was performed only once following the conclusion of medical record reviews.

The process involves the Cotiviti Quality Reporter application's Activate Oversample Records to Meet MRSS feature which identifies and inserts necessary substitutions from the oversample lists into the applicable sample populations when activated. When activating oversamples for CDC HbA1c Control <7% exclusions, the feature increases the denominator for all numerators until the <7% denominator is 411 or there are no more oversample members available. Should the number of remaining oversamples for a measure reach a specified minimum threshold greater than zero, HMSA QI will notify the auditor and consult on next steps to ensure MRSS is met.

The updated process was successfully implemented with no MRSS issues in HEDIS 2019.

2018 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of HMSA QI's 57 measure rates comparable to benchmarks, 28 measure rates (49.1 percent) ranked at or above the national Medicaid 50th percentile, with eight of these rates (14.0 percent) above the 75th percentile, indicating positive performance in immunizations for young children, well-child visits, body mass index (BMI) percentile documentation for children and adolescents, follow-up treatment for children after ED visits for alcohol and other drugs (AOD) abuse or dependence, follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication, and low ED utilization. Additionally, HMSA QI met four of the MQD Quality Strategy targets for HEDIS 2018.

Conversely, 29 of HMSA QI's measure rates that were comparable to national benchmarks (50.9 percent) ranked below the national Medicaid 50th percentile, with 18 of these rates (31.6 percent) below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

• Access to Care

– *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total*

• Children's Preventive Health

– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap*

• Women's Health

– *Chlamydia Screening in Women—21–24 Years*

– *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*

• Care for Chronic Conditions

– *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

– Controlling High Blood Pressure

– *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics*

• Behavioral Health

– *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*

– *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

– *Follow-Up After Emergency Department Visit for Mental Health Illness—7-Day Follow-Up and 30-Day Follow-Up*

Improvement Activities Implemented

Adult Access to Care

HMSA's Online Care (HOC) offers members an alternative source to care with 24/7 telephone or Web access to providers. HOC continues to expand and provides innovative services to members, including offering Web consultations or follow-up appointments for certain specialties.

Another option available to members that improves access to care is having urgent care providers located in clinics on Oahu, Maui, Hawaii Island, and Kauai. The urgent care clinics offer extended weekday hours, weekend and holiday hours, and can treat a wide range of conditions, except life-threatening emergencies.

In addition, HMSA continues to provide member education materials, such as articles in our quarterly member magazine or newsletters specific to lines of business, to increase member awareness of care options and to help members understand their role in obtaining appropriate, timely care.

Adolescent Preventive Care

HMSA has two programs, Payment Transformation and federally qualified health center (FQHC) Pay-for-Quality, in which part of a physician's compensation is tied to specific quality metrics. This shifts the physician incentive from volume to value. HMSA's quality payment programs have historically included (and continue to include) a measure for adolescent immunizations which encompasses Tdap, meningococcal, and Gardasil.

Women's Health

HMSA has two programs, Payment Transformation and FQHC Pay-for-Quality, in which part of a physician's compensation is tied to specific quality metrics. This shifts the physician incentive from volume to value. HMSA's quality payment programs have historically included (and continues to include) a measure for Chlamydia Screening in Women. Pregnancy Support Program: The program pairs pregnant members with a maternity registered nurse (RN) for telephonic education and referrals. RN support is intended to complement and encourage regular prenatal and postpartum care. The program RN maintains contact with the member from enrollment through the first month after delivery. The QUEST performance improvement initiative was developed to improve outreach to QUEST members. The Pregnancy Support Program is working with participating FQHCs to identify newly diagnosed pregnant members and offer additional resources. Pregnancy Support program advertisements are included in the summer and winter issues of the HMSA published Island Scene Magazine available at https://islandscene.com.

Care for Chronic Conditions

Informational themed mailings directed at a topic related to the condition was mailed to members and posted to the provider resource center for providers who wish to distribute Well-Being Resource program support materials to their patients. Members identified in groups 2 and 3 were referred to SRMs, CareFinder, special health care needs (SHCN), and Integrated Health Management Services (IHMS).

Behavioral Health

The Quality Management Program collaborates with other functional areas to ensure members have a high quality of life. This is done through health promotion, coordination of care across all settings, and using clinical practice guidelines to improve the overall wellness of our membership. Beacon used an

integrated health approach to improve behavioral health outcomes by reaching out to both members and their providers involved in their care.

Beacon's key primary activities entailed provider and member education surrounding HEDIS behavioral health measures and distribution of provider and member materials. Provider education was conducted through the distribution of educational materials for providers and members. Beacon's Psychiatric Decision Support Line was also offered to providers as a resource to consult with a Beacon board certified psychiatrist. While HMSA has a pharmacy advisor program benefit for its commercial and QUEST members, Beacon explored supplemental activities to implement that would not overlap with the program's activities.

Beacon continued its local Aftercare program. The goal of the program is to ensure that a follow-up appointment is scheduled and kept within seven days of discharge, by working closely with the discharging facility, member, and outpatient behavioral health provider. Additionally, Beacon launched a pilot that offers face-to-face Aftercare support at discharging facilities. To maximize end-of-year HEDIS rates, supplemental data are collected for confirmed "kept" appointments through the Aftercare program.

Beacon adopted the Transition of Care (TOC) model. This model uses Beacon staff to perform the post-discharge care within seven days of discharge. A service coordinator will conduct a telephonic appointment with the member within two business days of discharge. During the member communication, the service coordinator will contact the member and discuss the importance of medication and treatment adherence and discharge instructions, any laboratory tests that are required, community resources, and self-management techniques. Supplemental data will be submitted to demonstrate FUH compliance.

Provider engagement focuses on education and interventions in place to promote the importance of Aftercare and best practices of the HEDIS FUH measure. Facility visits are conducted quarterly throughout the year. During these visits, Beacon encourages that facility discharge planning begin at the start of admission and that scheduling of Aftercare appointments should be accomplished (by the facility) prior to discharge. Effective and timely discharge planning ensures continuous and coordinated behavioral healthcare treatment for patients following discharge from an acute care facility. Outpatient follow-up care with a behavioral health provider after inpatient admissions can provide the necessary continuity of care that people with acute and chronic mental health disorders require. Outpatient follow-up care also supports a patient's return to baseline functioning in a less restrictive level of care.

CAHPS—Adult Survey

2018 Recommendations

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Needed Care, Getting Care Quickly,* and *Coordination of Care.*

Improvement Activities Implemented

Getting Needed Care—To simplify and streamline the referral process and to ensure that members have access to care when they need it, HMSA revised its referral process for specialty care. Beginning in

January 2015, PCPs only need to register referrals with HMSA for off-island specialty care, referrals to nonparticipating providers, plastic surgery, rehabilitation services, and dermatology services. Although a registered referral is no longer required, PCPs and specialists must still keep records of referral in their patient record.

Getting Care Quickly—Providers are encouraged to open scheduling and provide additional ways for members to access a care team through telephone, secure electronic messaging, or other means. HMSA provides a 24-hour nurse advice line that members can call to talk with a nurse, answer questions, and determine whether a member should see a doctor or go to the emergency room. HMSA's 24-hour nurse advice line can also refer a member to a participating provider. For members that are chronic no-shows, providers have the option of referring the member for service coordination. The service coordinator assigned to the member will assist with identifying barriers, developing a service plan, and coordinating services that will support the member's needs and reduce no-shows.

Coordination of Care—PCPs are reminded about the importance of effective doctor-patient communication to continually discuss and review clinical needs and coordination of care between specialists, and other providers managing the care of the member. HMSA will routinely provide updates and reminders via HMSA's monthly provider newsletter to the providers to ensure coordination of care for our members.

Provider Survey

2018 Recommendations

Based on the survey results, HMSA QI should focus efforts on improving the following measure which scored statistically significantly lower than the QI Program aggregate:

• Adequate Access to Non-Formulary Drugs

Improvement Activities Implemented

The HMSA QUEST Integration Formulary is based on scientific evidence, standards of practice, peer reviewed medical literature, and accepted clinical practice guidelines. The formulary is managed, drives generic use, uses over-the-counter products, and is customized to meet the clinical needs of HMSA's QUEST Integration membership and local prescribing patterns. The formulary is fortified with select brand drugs, which have been determined to be medically necessary when equivalent generic drugs are not available, or the brand drug offers better therapeutic outcomes or a more favorable safety profile.

HMSA has implemented the following programs to improve access to non-formulary drugs:

• In 2019, HMSA updated the QUEST Integration Non-Formulary Exceptions Criteria located at: https://hmsa.com/portal/PROVIDER/CVS_Formulary_Exception_PA_Form_QUEST_Integration.pdf.

– Extended the approval duration for generic non-formulary medications from 12 months to 36 months.
– Non-formulary medications that do not have therapeutic formulary alternatives will be approved.

– Allow an exceptions review for certain types of controlled substances (e.g., Epidiolex).

– All PA requests are approved or denied within 24 hours of receipt.

• Providers can request a non-formulary medication be added to the HMSA QUEST Integration Formulary if it offers a distinct clinical advantage over medications on the formulary. The application form is located at: https://hmsa.com/portal/PROVIDER/Application_for_Formulary_Review.pdf.

– In 2019, HMSA added six medications (Crinone gel, Chemet, pentoxifylline, Vitamin E, atropine, and Lotemax gel) to the QUEST Integration Formulary as a result of feedback obtained from the local provider community.

• HMSA established a pharmacy prior authorization workgroup that monitors and analyzes the prior authorization process for areas of opportunities to improve member and provider experiences. Clinical pharmacists provide recommendations for formulary and utilization management opportunities based on trends seen by routinely monitoring prior authorization reports and appeal decisions.

HMSA also has a Prior Authorization process for providers that simplifies and minimizes administrative burdens. This includes Electronic Prior Authorization, Smart PA program, Real Time Benefits etc. These processes assist providers with access to non-formulary drugs, and additional information about the processes is available on request.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of KFHP QI's 55 measure rates comparable to benchmarks, 43 measure rates (78.2 percent) ranked at or above the national Medicaid 50th percentile, with 19 of these rates (34.5 percent) ranking at or above the national Medicaid 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 10 of the MQD Quality Strategy targets for HEDIS 2018: *Childhood Immunization Status—Combination 3; Cervical Cancer Screening; Prenatal and Postpartum Care—Timeliness of Prenatal Care; Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure; and Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*.

Conversely, 12 of KFHP QI's measure rates that were comparable to national benchmarks (21.8 percent) ranked below the national Medicaid 50th percentile, with only one of these rates (1.8 percent) below the 25th percentile, suggesting some opportunities for improvement exist. HSAG recommends that KFHP QI focus on improving performance related to the following measure with a rate that fell below the national Medicaid 25th percentile for the QI population:

• Care for Chronic Conditions

– *Medication Management for People With Asthma—Medication Compliance 50%—Total*

Improvement Activities Implemented

The following table depicts the three-year trend results for the *Medication Management for People with Asthma* measure recommended for improvement. HEDIS 2019 results indicate that improvement was achieved during 2018 measurement.

	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate
Medication Management for People With Asthma (mma)			
Total Medication Compliance 50%	42.02%	48.89%	58.85%

An evaluation of the barriers and the activities implemented as part of our quality improvement process is also outlined as follows:

Continued improvement has been seen in the 50 percent compliance rate.

Barriers: The specifications for this measure are complex which makes it very difficult to obtain the data needed to create an actionable report of noncompliant members.

Activities:

• The quality initiative of clinical pharmacists and specialists targeting patients who were not compliant or at target was continued.

• Kaiser clinical pharmacists and pharmacy technicians proactively conducted monthly outreach targeting members ages 5–64 from hub clinic locations with an asthma medication ratio of less than 0.5. Member education focused on appropriate use of controller medication versus rescue inhaler, timeliness of refills, proper use of device, and general asthma education.

• MD specialists performed chart reviews and sent notices to PCPs to educate members regarding asthma management.

CAHPS—Adult Survey

2018 Recommendations

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Care Quickly, Getting Needed Care,* and *Coordination of Care*.

Improvement Activities Implemented

Getting Care Quickly and Getting Needed Care

The 2018 results for the areas of *Getting Care Quickly* and *Getting Needed Care* remain flat with no statistically significant changes compared to our 2016 results. The following improvement activities are currently being worked on to address these areas.

• **Appointment Call Center**

– Improvements to streamline the appointment call center process and member experience.

• **Online Appointment Booking**

Kaiser Permanente Hawaii has added specialty departments that allow online appointment booking, making it easier for members to obtain care. Currently, the following appointments are always available for online booking:

– Primary care same day

– Cosmetic services

– Eye care services

– Hearing aid services

– Physical therapy

– Sports medicine

– Knee and hip replacement classes

– Weight management information sessions

Also available for online booking with criteria:

• Mammograms and Well Woman physicals—only displays to women and can only be scheduled once a year

• Allergy consults—only display to patients who have NOT had an allergy appointment within 18 months
• Medicare Wellness—only displays to patients 65 and older

• Cataract consults

• Bariatric surgery follow-ups

Coordination of Care

Although there was a slight increase in the 2018 results for the area of Coordination of Care as compared to 2016, the increase was not statistically significant. The following improvement activities are currently being worked on to address this area:

• Service coordinator, in collaboration with PCPs and the Health Care Team, provides oversight of member care coordination across the continuum of services.

• Continuous Health Care Team education and process improvement of the service coordinator's role in order to improve the care coordination process and the member's experience.

Provider Survey

2018 Recommendations

Based on KFHP QI's performance, no critical areas in need of improvement were identified.

Improvement Activities Implemented

Not applicable

‘Ohana Health Plan QUEST Integration (‘Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

Based on ‘Ohana QI’s data systems and processes, the auditors made one recommendation:

• HSAG recommended that ‘Ohana QI ensures appropriate Roadmap documentation for supplemental data going forward.

Improvement Activities Implemented

Wellcare and Ohana’s HEDIS Team and IT team will ensure close review of each data source submitted in Section 5 and validate applicability to the HI Market prior to submission to ensure accurate Roadmap documentation is provided. Additionally, the Quality Data Analytics and Reporting (QDAR) HEDIS Team will run impact reports on each source in advance to identify measures that would be affected by each supplemental data source.

2018 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of ‘Ohana QI’s 54 measure rates comparable to benchmarks, only 11 measure rates (20.4 percent) ranked at or above the national Medicaid 50th percentile, with five of these rates (9.3 percent) above the 75th percentile but below the 90th percentile, indicating positive performance in medication management of members with asthma, care for members with diabetes, and monitoring of members on persistent medications. Additionally, ‘Ohana QI met three of the MQD Quality Strategy targets for HEDIS 2018: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed; and Medication Management for People With Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total*.

Conversely, 43 of ‘Ohana QI’s measure rates that were comparable to national benchmarks (79.6 percent) ranked below the national Medicaid 50th percentile, with 28 rates (51.9 percent) below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

• Access to Care

– *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total*

– *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*

• Children’s Preventive Health

– *Adolescent Well-Care Visits*

– *Childhood Immunization Status—Combination 3, DTaP, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, and VZV*

– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap*

– *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

• Women's Health

– *Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total*

– *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*

• Care for Chronic Conditions

– *Comprehensive Diabetes Care—HbA1c Control (<7.0%)*

• Behavioral Health

– *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*

– *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Improvement Activities Implemented

The following improvement activities were implemented to address multiple measures/domains of care:

2019 Medicaid Partnership for Quality (P4Q) Program

• Ohana's 2019 Medicaid Partnership for Quality (P4Q) recognizes providers who collaborate with Ohana to deliver high-quality care. Through the P4Q program, providers are able to obtain financial incentives to close care gaps for eight HEDIS measures including *Adolescent Well-Care Visits; Cervical Cancer Screening; Comprehensive Diabetes Care—HbA1c Control (<8.0%) and HbA1c Testing; Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care; and Well-Child Visits in the First 15 Months of Life and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Ohana supports providers by working to educate them about the program, in-person delivery by quality practice advisors (QPAs) of current member/measure-specific quality Care Gap Reports (also available via the provider portal), reaching out to members on behalf of the provider to schedule appointments/discuss care needs, and providing general educating on coding and standards of care.

• For the second half of 2019 (July 15–December 31), providers can earn an additional $10 in addition to the current amount per measure for closing care gaps for *Comprehensive Diabetes Care—HbA1C Testing and HbA1c Control (<8.0%); and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

2019 Healthy Rewards

• The Ohana Healthy Rewards program incents members and encourages them to take care of their health by providing Visa debit cards, gift cards and/or Bonus Rewards (for completion of multiple visits or services). This program incents members to complete visits touching on 11 HEDIS measures and also includes an annual adult health screening. HEDIS measures that are incented include *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care; Comprehensive Diabetes Care—HbA1C Testing, HbA1c Control (<8.0%), and Blood Pressure Control (<140/90 mm Hg); Cervical Cancer Screening; Breast Cancer Screening; Chlamydia Screening*; and behavioral health follow-up measures.

Preventive Care Outreach—Unable to Contact

• Ohana's patient care advocates (PCAs) provide outbound calls to members to encourage them to make or to help schedule an appointment with their primary care provider to address preventive care services. When the PCA is unable to contact members by phone after multiple attempts, unable to contact letters for established patients are sent that identify services which are overdue (including Annual Wellness Visit, Breast Cancer Screening, Well-Woman Exam, Colorectal Cancer Screening, Well-Child Visit, and Immunizations) and asking members to contact their PCP (name and phone number included in the letter). The letter also includes information regarding how to schedule transportation and the PCA's phone number to call if the member needs help scheduling an appointment. A similar letter is sent to members who have an assigned PCP but have not yet established care with that assigned PCP. The letter also provides members with information regarding how to change their PCP if needed.

Access to Care

Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years

Improvement Activities Implemented in 2019:

• Ohana promotes access to care for children, adolescents, and adults by encouraging annual wellness visits; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits; and well-care and well-child visits in accordance with specified age groups and time frames. This is completed via member and provider education as well as member and provider incentives throughout the year.

Children's Preventive Health

Adolescent Well-Care Visits

Childhood Immunization Status—Combination 3, DTaP, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, and VZV

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Improvement Activities Implemented in 2019:

• Birthday cards are sent to pediatric and adolescent members turning 1 to 20, a month in advance of their birthday month as a reminder to go into their primary care physician's office for a well-child visit and to inform them of the importance of a well-child visit.

• Reminder letters are sent to pediatric and adolescent members with upcoming birthdays in a month turning 1 to 20 that have not had a visit to see their primary care physician's office for a well-child visit. The reminder letter informs the parents/guardians on the importance of a well-child visit and what to expect in the visit.

• Periodicity letters are sent to remind parents/guardians to schedule well-visits and keep up to date with immunizations for their child.

• Patient care advocates (PCAs), care gap coordinators (CGCs), and service coordinators (SCs) are outreaching to parents/guardians of pediatric members to educate and assist with scheduling appointments for well visits and to obtain missing immunizations.

• Healthy Rewards for well-child visits in the third, fourth, fifth, and sixth years of life. Parents/guardians are given the option on a $25 Visa debit card or gift card for taking their children in for a well-child visit.

• New well-child visit flyers for parents/guardians with information on when well-child visits are recommended, what a well-child visit entails, how a sports physical can be done with a well-child visit, and transportation availability and information.

• Quality practice advisers (QPAs) and/or PCAs provide providers with noncompliant member lists.

• Providers are mailed noncompliant member lists for members not seen for more than 120 days.

• A P4Q Program Enhancement Bonus is offered for Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (additional $10 per gap closed in addition to the $35 that is currently part of P4Q).

Women's Health

Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care

Improvement Activities Implemented in 2019:

• Prenatal and postpartum member outreach via Ohana care gap coordinators

• Healthy Rewards Program: $25 for prenatal, postpartum and chlamydia screening

• Bonus Rewards for PPC: Choice of stroller, car seat, playpen, or diapers upon completion of a prenatal and postpartum care visit

• Disease management outreach to high-risk pregnant members

Care for Chronic Conditions

Comprehensive Diabetes Care—HbA1c Control (<7.0%)

Improvement Activities Implemented in 2019:

Behavioral Health

Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up

Improvement Activities Implemented in 2019:

• Care gap coordinators outreach to members to facilitate follow-up appointments within seven days of discharge.

• Ohana has contracted with a licensed mental health counselor to perform face-to-face visits with the member to perform follow-up within seven days of discharge from two of the main facilities on Oahu.

• Behavioral health follow-up appointment available via MD Live functionality (telehealth).

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

• Pharmacy team created an educational flyer for the providers to deliver the information on the best practice for members who are taking antipsychotic medications to obtain diabetes screening annually.

• Pharmacy team also visited behavioral health (BH) and PCP offices to discuss the importance of diabetes screenings/monitoring for members taking antipsychotic medication.

• QPAs provide education and trainings on quality-related services for PCPs and have made efforts to connect with all BH providers (psychiatrists, advanced registered nurse practitioners (ARNPs), and physician assistants) in the market. Then, QPAs provided an educational flyer specifically on diabetes screenings for people taking antipsychotic medication and provided guidance on best coding practices when billing.

CAHPS—Adult Survey

2018 Recommendations

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Coordination of Care, Getting Care Quickly,* and *Customer Service*.

Improvement Activities Implemented

Coordination of Care

Transition Management Coordination Program (TMC)

• Through the TMC Program, initial assessments are conducted within 24 hours of referral to the program for members who have had an inpatient admission. The program's target population are members who remain in a hospital setting post-acute level of care and/or who are inpatient but have been readmitted within 30 days of discharge date or hospitalized at least four times in the past 12 months. Enrolled members receive in-person service coordination for as long as they remain inpatient and as frequently as needed to address problematic discharge barriers. In addition, the program provides telephonic and/or in-person case management up to 30 days post-discharge to prevent readmission.

• The TMC Program's primary focus is to coordinate timely and safe transition of members from a hospital setting to the next stage of care; prevent readmission; and build strong, meaningful relationship with the hospital's discharge planning team. The program addresses discharge barriers such as unsafe home environment; psychosocial behavior, cognitive issues, poor availability of foster home and/or nursing facility beds, lack or absence of caregiver; unpreparedness of family to care for member; and absence of necessary equipment, supplies, and/or resources at the member's home. The TMC Program mitigates readmission risk by promoting effective communication and coordination across the care continuum.

Getting Care Quickly

• Ohana has updated the Access to Care process to ensure timely resolution to access to care issues. Customer service representative agents will call a minimum of three providers to see if they can see the

patient within the required time frames. If they are unsuccessful, they will escalate the issue to our offline team who will continue to call providers until they are able to successfully get the member scheduled with a provider within the required time frames.

– Empowered agents to work directly with the member's PCP. If we do not have the needed specialist on the member's home island, the agent will work with the member's PCP to initiate a travel request so the member can be seen on a neighbor island.

– Provider Services continues to focus on network adequacy and expansion to assure the availability of PCPs across the State.

– Reference cards reflecting Ohana appointment accessibility standards have been distributed to PCP offices. Mousepads are in development for distribution in the fourth quarter of 2019.

– Continue to work with providers to determine what we can do to support providers opening their panels.

Customer Service

• All agents completed the Uplifting Service Training to improve the overall experience for our members and providers who call into the call center.

• Created and or updated call tools as process flows were added or changed. Provided training to staff on these new or updated call tools.

• Ongoing training at department meetings and morning huddles.

• Implemented creative ways to help make learning of important information needed fun and engaging including:

– Created a crossword activity to help reinforce the correct answers to pharmacy questions and where to find them.

– Testing and Reinforcing the Importance of CAHPS Crossword Puzzle.

– Reinforcing the Importance of CAHPS Department Presentation and Word Search activity.

– March Knowledge Check

—Word Search: Created a word search with words that the agents deal with daily while on calls. It was a two-part question sheet where the answer to the question is the word you would search for.

– Call-Taking BINGO: We played BINGO using caller types, over-the-counter (OTC) items, call drivers, and the Ohana Mobile App to have the agents be familiarized with topics.

– Pop Quiz: Created a pop quiz of 15 questions regarding the Health Insurance Portability and Accountability Act (HIPAA), call drivers, and call tools.

– Operation Man Brain Teaser: We made a worksheet of the Operation man [based on Hasbro's Operation board game], and the agents had to figure out which specialist would be able to assist with the body part issue.

– Shining Stars Call Award for providing Shining Star Service to members and/or providers.

Provider Survey

2018 Recommendations

Based on the survey results, ‘Ohana QI should focus efforts on improving the following measures which scored statistically significantly lower than the QI Program aggregate:

• *Compensation Satisfaction*

• *Timeliness of Claims Payments*

• *Prior Authorization Process*

• *Formulary*

• *Adequate Access to Non-Formulary Drugs*

• *Helpfulness of Service Coordinators*

• *Adequacy of Specialists*

• *Adequacy of Behavioral Health Specialists*

• *Availability of Mental Health Providers*

• *Access to Substance Abuse Treatment*

Improvement Activities Implemented

Compensation Satisfaction

• We address compensation concerns with our participating providers for network adequacy purposes and to strengthen our network. For example, in 2019 we renegotiated rates with a key pediatric practice and a custom wheelchair provider. We also established a contract with a key specialty surgeon at higher rates. In addition, all of our PCPs have the opportunity to earn additional payments through our pay for quality (P4Q) program that encourages providers to close a wide array of care gaps.

Timeliness of Claims Payments

• We made a number of successful changes to our claims processing approach in order to speed up claims payments. Our average claims turnaround time (TAT) decreased from 10.7 days in January 2019 to 6.5 days in August. In addition, 94 percent of claims had a TAT of 10 days or less in August, as compared to 70.5 percent of claims in January.

Prior Authorization Process

• In 2018 we removed prior authorization requirements for close to 14,000 services. In 2019, we evaluated some services for which we continued to require prior authorizations (PA) and modified some of those requirements. For example, we removed PA requirements for psychotherapy services after a certain number of visits had occurred and are instead monitoring claims for outlier utilization. We continue to evaluate services for which post-utilization review makes more sense than requiring a PA.

Formulary

• We update our formulary on a quarterly basis when we usually add more drugs than remove.

Adequate Access to Non-Formulary Drugs

• We have a user-friendly prior authorization process for non-formulary drugs. Our staff will meet face-to-face with providers to help remove any barriers for these providers when clinical judgement establishes medical necessity.

Adequacy of Specialists

• Hawai'i struggles with a shortage of certain specialists, particularly on the neighbor islands. We continually work to identify and contract with additional specialists across the islands. We reach out to certain providers time and again, attempting to find a way to contract with them. We are currently conducting phone outreach to our PCPs to attempt to identify specialty types and specific specialists that they have had difficulty referring our members to so that we can focus on recruiting these providers to our network.

Adequacy of Behavioral Health Specialists

• Hawai'i also experiences shortages of behavioral health providers, in particular psychiatrists who do not want to contract with Quest Integration MCOs. In mid-May of this year, we initiated a telehealth service, MDLive, that offers behavioral health services and has two psychiatrists and two counselors on its Hawai'i roster. We are informing our PCPs and our members about the availability of MDLive. Through August, 7 behavioral health sessions had occurred.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of UHC CP QI's 54 measure rates comparable to benchmarks, 21 measure rates (38.9 percent) ranked at or above the national Medicaid 50th percentile, with 11 of these rates (20.4 percent) above the 75th percentile, indicating positive performance in several areas, including well-child visits for young children, BMI percentile documentation for children and adolescents, medication management for members with asthma, care for members with diabetes, and monitoring of members on persistent medications. Additionally, UHC CP QI met four of the MQD Quality Strategy targets for HEDIS 2018: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Eye Exam (Retinal) Performed; and Medication Management for People With Asthma—Medication Compliance 75%—Total*.

Conversely, 33 of UHC CP QI's measure rates that were comparable to national benchmarks (61.1 percent) ranked below the national Medicaid 50th percentile, with 22 of these rates (40.7 percent) below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

• Access to Care

– *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years and 45–64 Years*

– *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*

• Children's Preventive Health

– *Childhood Immunization Status—Combination 3, DTaP, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, and VZV*

– *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap*

– *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*

– *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

• Women's Health

– *Cervical Cancer Screening*

– *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*

• Behavioral Health

– *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Improvement Activities Implemented

The following activities were implemented by the UnitedHealthcare Community Plan Hawai'i (UHC CP HI) in 2019 to address HEDIS measures that fell below the national Medicaid 25th percentile in 2018:

• **Access to Care**

– *Adults' Access to Preventive/Ambulatory Health Services (AAP)—20–44 Years and 45–64 Years*

– *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years, and 12–19 Years*

o In the current Member Handbook, members are informed of the time frames within which they can expect to get an appointment for primary care services, as well as for specialty and behavioral health (BH) services.

o In the Summer 2019 Member Newsletter, an article titled, "Wait No More," listed the appointment time frames within which members could expect to be seen for routine, emergency, urgent, specialty, and BH care, for both children and adults.

o In 2019, UHC CP QI transitioned the Health Disparities Action Plan, which addressed some of the barriers for AAP, to widen the scope of addressing and reducing healthcare disparities by proceeding with the NCQA Multicultural Healthcare (MHC) distinction process. The MHC distinction survey submission was completed on September 23, 2019.

o In 2019, through the Advocate4Me delivery model, customer service advocates (CSAs) continued to assist members with urgent and nonurgent appointment scheduling and facilitating transportation services. CSAs also help connect members to service coordinators and interpreter services when needed.

o Through the Appointment Setting Campaign, CSAs are alerted if a member is due for preventive care or other important healthcare visits. In May and July 2019, trainings to Member Services staff included information on a proactive preventive care monitoring process: Rather than relying only on alerts that appear on each call, CSAs proactively review preventive care claims activity on every call to identify any care gaps, hold gap conversations, and offer to schedule appointments. This topic will be on the planned agenda for new hire training classes.

o UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete primary care/preventive care visits, including well-child (3–6 years old) and adolescent (12–21 years old) well-care visits, cervical cancer screening, and postpartum care. The gift card amount increased from $10 in the 2018 MRP.

o Clinical practice consultants (CPCs) from the UHC CP QI Quality Team established and developed relationships with OB/GYNs [obstetricians/gynecologists] and pediatricians through engagement in the Community Plan—Primary Care Professional Incentive (CPPCPi) program, which offers bonuses to providers for closing care opportunities with their members. These care opportunities target preventive services, such as well-child and adolescent well-care visits, childhood immunization, cervical cancer screening, timely prenatal and postpartum care, and HbA1c screening.

o A 2019 Interactive Voice Response (IVR) outreach call campaign to members is being conducted by Silverlink/Welltok to provide education and reminders, and to address the AAP measure.

• **Children's Preventive Health**

– *Childhood Immunization Status (CIS)—Combination 3, DTaP, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, and VZV*

– *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap), Meningococcal, and Tdap*

– *Well-Child Visits in the First 15 Months of Life (W15)—No Well-Child Visits*

– *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*

o UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete W34 and adolescent well-care (AWC) visits. The gift card amount increased from $10 in the 2018 MRP.

o UHC CP QI participated in the UnitedHealthcare Baby Blocks program, which is a web-based mobile tool that allows eligible members to earn rewards for attending and tracking well-child care visits for children up to 15 months old.

o Quality CPCs established and developed relationships with pediatricians through engagement in the CP-PCPi program, which offers bonuses to providers for closing care opportunities with their members. These care opportunities include well-child and AWC visits and CIS— Combination 3.

o UHC CP QI’s EPSDT RN coordinator engaged the pediatric population through various activities, such as working with complex cases, mail-outs for welcome and birthday postcards and delinquent notifications, and education through community events.

o The EPSDT RN coordinator also engaged providers through outreach calls and face-to-face training sessions that emphasized the importance of timely well visits and vaccinations for their patients.

o An IVR outreach call campaign is being conducted by Silverlink/Welltok this year to remind members to schedule W15, W34, AWC, and EPSDT visits for their children.

o In Q3 2019, the clinical quality manager conducted interdepartmental “Fast & Furious” training sessions on key HEDIS pediatric measures, including CIS—Combination 3, W15, W34, and AWC.

o Materials for the Vaccine Adherence in Kids (VAKs) program are being finalized for distribution. This is a vaccination reminder program sponsored by Pfizer that targets parents of children at ages 6 months, 8 months, and 16 months. There is also a well visit reminder for the first-year checkup that targets parents of children at 10 months of age.

• **Women’s Health**

– *Cervical Cancer Screening (CCS)*

– *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and Postpartum Care*

o The Postpartum Program was recently added as a UHC CP QI Disease Management program in Q3 2018 and is ongoing in 2019. All pregnant women are enrolled in the program and receive a call after delivery to remind them to attend their postpartum visit. Members are offered assistance with scheduling the appointment and transportation for the appointment if needed. A follow-up call is made to verify that the member actually attended the scheduled postpartum visit, and then a final call is made at 60 days after delivery to close out the case.

o The Hāpai Mālama program focuses on prenatal care management, with the goal to optimize the health and well-being of all pregnant members, with particular attention given to individuals with a high-risk pregnancy and special healthcare needs. Members are given information and support on pregnancy management, including but not limited to prenatal appointments and transportation, translation services, and tobacco cessation. Members identified as having a high-risk pregnancy receive a comprehensive special health care needs face-to-face assessment.

o To address and reduce health care disparities, in 2019 UHC CP QI began the application process for the NCQA Multicultural Healthcare (MHC) distinction. PPC was targeted as a measure to explore the impact of member language on receiving timely prenatal and postpartum care and whether any disparities exist.

o UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete CCS and PPC postpartum care. The gift card amount increased from $10 in the 2018 MRP.

o Quality CPCs established and developed relationships with OB/GYNs through engagement in the CP-PCPi program, which offers bonuses to providers for closing care opportunities with their members.

These care opportunities target preventive services and include CCS and timely prenatal and postpartum care.

o In May 2019, Women's Healthcare emails went out to eligible female members ages 18 and older to encourage completion of recommended health screenings, including CCS.

o In Q3 2019, the clinical quality manager conducted interdepartmental "Fast & Furious" training sessions on key HEDIS measures, including CCS and PPC.

o UHCCP QI participated in the UnitedHealthcare Baby Blocks program, which is a web-based mobile tool that allows eligible pregnant members to earn rewards for attending and tracking provider visits for prenatal and postpartum care visits.

o An IVR outreach call campaign is being conducted by Silverlink/Welltok this year to remind members to schedule timely prenatal and postpartum visits. A call campaign for CCS will be launched later in 2019.

• **Behavioral Health (BH)**

– *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

o In July 2019, an educational email was sent to 83 Hawai'i BH practitioners who treated adults diagnosed with schizophrenia and/or bipolar disorder within the past 12 months. Email content included best treatment practices, information on the need for metabolic screening, HEDIS specifications, and patient and provider resources. Planning for a Q4 2019 mail-out to both BH prescribers and PCPs is underway. The letter will inform practitioners of patients who have a schizophrenia disorder diagnosis and/or have been prescribed antipsychotic medication if they have also not had an HbA1c and/or LDL-C testing completed this year.

CAHPS—Adult Survey

2018 Recommendations

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Customer Service, Coordination of Care,* and *Getting Needed Care*.

Improvement Activities Implemented

In Q2 2019, a new executive owner for our CAHPS workgroup was assigned along with the accountable owners and supporting team members from the health plan. They were assigned to each Patient Experience measure (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Enrollees' Ratings*). The Coordination of Care measure was added in Q3. The workgroups were tasked to conduct a root cause analysis and develop action plans to address and improve member experience in their assigned area. The results of 2020 CAHPS will be analyzed to determine if improved member experience was achieved. Action plans are reviewed quarterly at designated quality committees.

• **Customer Service**

– Advocate4Me (A4Me) is UHC CP QI's Customer Service delivery model that provides members with support to address their healthcare needs and successfully navigate the healthcare system. In Q2 and

Q3 2019, A4Me was reinforced during CSA staff meetings. The reinforcement training included reviewing the definition of the A4Me model, communicating expectations, and providing examples of service delivery.

– The UnitedHealthcare National Learning Solutions team provided training to CSAs in Q1 2019 on commitment setting with members and providing end-to-end customer service.

– Ownership of CSA call audits with members transitioned from the Business Process Quality Management team to Member Services management in May 2019 to improve Quality Assurance oversight. Auditors are required to conduct four audits per CSA per month, and audits place a greater emphasis on A4Me delivery.

– In Q3 2019, the CAHPS Customer Service workgroup developed and piloted a questionnaire to be used at quarterly Member Advisory Group (MAG) meetings across the State to gain member insight on UHC CP QI's strengths and weaknesses related to member experience. The questionnaire was first used at the 8/23/2019 MAG meeting on Oahu, and feedback was shared among the internal workgroups. The questionnaire will continue to be used as a discussion tool at future MAG meetings.

– At the 8/23/2019 Oahu MAG meeting, UHC CP QI staff provided members with information on the A4Me model and the services that CSAs provide. Services mentioned include assistance in finding a provider and scheduling appointments, arranging transportation for medical care, connecting to a service coordinator or other support resources, coordinating interpreter services if needed, and help with billing issues. Staff emphasized to members that CSAs are firmly committed to helping them resolve any healthcare system issues or concerns they may have. Member education on A4Me will continue in future MAG meetings.

– UHC CP QI established Self-Direct Provider Orientations to educate self-direct providers on processes and guidelines related to timesheet completion and submission deadlines, payment turnaround times, and time frames for a UHC CP QI self-direct team response. The orientations began as a pilot with one Oahu Service Coordination team in December 2018, and they have since been rolled out to all Service Coordination teams across Oahu in 2019. To date, 94 self-direct members/providers have completed the orientation. A pilot with the Hilo Service Coordination team is scheduled to begin in Q4 2019.

– CSAs started sending handwritten "Compassion Notes" to members in 2017 that contain phrases of positivity and kindness, and that practice is ongoing in 2019. In Q3 2019, a new coordinator was assigned to the project to keep track of all Compassion Notes and ensure that CSAs are creating and sending two to three notes per week to members.

– UHC CP QI continues to hold weekly meetings with our transportation vendor. Incident reports, including issues and complaints related to Customer Service, are shared at these meetings and are communicated back to the vendor staff to address areas for improvement.

• **Coordination of Care**

– A link to a 2019 article titled, "CAHPS: Importance of Care Coordination," is posted on the UnitedHealthcare provider website at www.uhcprovider.com. The one-page resource explains what the CAHPS survey is and focuses specifically on the survey questions related to Care Coordination. It also lists ideas to help providers improve their patients' experience with Care Coordination.

– The Spring/Summer 2019 “Practice Matters” Provider Newsletter included an article that highlighted UHC CP QI’s partnership with Hawai’i Health Information Exchange (HHIE). HHIE can help providers find and share clinical information that supports care coordination and continuity of care.

– UHC CP QI will publish an article in the Fall/Winter 2019 “Practice Matters” newsletter that offers providers resources to address barriers to care delivery and coordination related to language. The article will include the link for Medline Health Information in multiple languages (https://medlineplus.gov/languages/languages.html), as well as information on Language Line and Helping Hands services.

– The Service Coordination team will have a table at the Q4 2019 Provider Information Expo (PIE). Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a Service Coordinator can provide, including care coordination and supporting members with getting needed care.

• **Getting Needed Care**

– A link to a 2019 article titled, “CAHPS: Improving Getting Needed Care,” is live on the UnitedHealthcare provider website at www.uhcprovider.com. The one-page resource explains what the CAHPS survey is and focuses specifically on the survey questions related to *Getting Needed Care*. It lists ideas to help providers improve their patients’ experience with *Getting Needed Care*.

– In the Spring 2019 “Health Talk” Member Newsletter, a checklist insert was included to help members prepare for PCP visits and get needed care by identifying and prioritizing items for discussion. The CAHPS workgroup is discussing the use of the checklist by service coordinators to use as a tool when helping members prepare for provider visits.

– In the Summer 2019 “Health Talk” Member Newsletter, an article titled, “Wait No More,” listed the appointment time frames within which members could expect to be seen for routine, emergency, urgent, specialty, and BH care, for both children and adults.

– The Summer 2019 “Health Talk” Newsletter also included an article titled, “Getting the Right Care.” It encourages members to see their PCPs when possible and gives general guidelines and situations when members should seek urgent or emergency care, so that members obtain the care they truly need. The number for the UnitedHealthcare NurseLine is provided for general health questions.

– Through A4Me, CSAs help members schedule provider appointments while on the call with the member or commit to do so within the next 48 hours if immediate scheduling is not possible. UHC CP QI has started emphasizing A4Me and its services at quarterly MAG meetings in 2019, and this agenda item will be ongoing.

– The Service Coordination team will have a table at the Q4 2019 PIE. Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a service coordinator can provide, including care coordination and supporting members with getting needed care.

– The health plan continues to explore telehealth options to expand member access to needed care for physical health.

o We are currently working with MDLive to provide direct-to-consumer virtual visits that members access through a Web portal or mobile app. The service is for physical health visits only, and visits are at no cost to members.

o UHC CP QI continued its contract with Direct Dermatology in 2019 to provide dermatological care to our members through its online platform.

– To facilitate member access to needed BH care, UHC CP QI is planning as well as already implementing several initiatives in 2019:

o Utilization of the Express Access Network, which is a network of BH clinicians who have an addendum to their contract agreeing to have appointments available within five days of a member's request for an appointment. Our online directory allows for filtering by clinicians who have this availability. Currently, all participating clinicians are non-prescribers.

o We have a network of BH clinicians who have attested to having telehealth capability with technology that has been verified and confirmed to meet our standards, in order to provide care via virtual visits.

o UHC CP QI collaborated with Paniolo Pediatrics and Family Medicine on Hawai'i Island to provide members with access to BH clinicians through UnitedHealthcare-sponsored computers that were placed in the clinic. Implementation began in Q3 2019.

o In 2019, UHC CP QI developed an incentive program for BH providers to receive $50 for each of our eligible members they see for follow-up within seven days after discharge, to reinforce the HEDIS *FUH (Follow-up after Hospitalization for Mental Illness*) measure. The target effective date is 1/1/2020.

o At the Q4 2019 PIE, the BH team will have a booth to educate providers on its services, including the Express Access Network of BH providers, who have agreed to have appointments available within five days of request, and how members can access it.

o The BH team also has plans to train the Service Coordination team on the Express Access Network, how to identify participating providers, and how members can access the network. Training is planned for one of the Service Coordination team's weekly Webex meetings.

Provider Survey

2018 Recommendations

Based on the survey results, UHC CP QI should focus efforts on improving the following measures which scored statistically significantly lower than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Formulary*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Service Coordinators*

• *Adequacy of Specialists*

• *Adequacy of Behavioral Health Specialists*

• *Availability of Mental Health Providers*

• *Access to Substance Abuse Treatment*

Improvement Activities Implemented

• **Compensation Satisfaction**

– For medical providers, UHC CP QI has developed two new fee schedules that went into effect October 2018. Historically, UHCCP relied on the published Hawaii State Fee Schedule. These two new fee schedules were developed to be inclusive of all covered Medicaid benefits, as well as to be competitive among the other health plans in the market:

o UHCCP PCP Enhanced Fee Schedule: The providers who qualify for Patient Protection and Affordable Care Act (PPACA) PCP Enhancement payments will receive full payment up front as part of the new fee schedule specific to providers who qualify.

o UHCCP Standard Fee Schedule: Providers who do not qualify for the UHCCP PCP Enhanced Fee Schedule will be reimbursed based on the new UHCCP Standard Fee Schedule.

– For BH providers:

o The fee schedule was revised to be more in line with the market standards and resulted in an increase across the board for our BH providers. The effective date is 10/1/2019.

o In 2019 UHC CP QI planned and developed an incentive program for BH providers to receive $50 for each of our eligible members they see for follow-up within seven days after discharge, to reinforce the HEDIS FUH (*Follow-up after Hospitalization for Mental Illness*) measure. The target effective date is 1/1/2020.

• **Timeliness of Claims Payments**

– UHC CP QI's Standard Operating Procedures were reviewed to ensure claims are processed through the system in a timely manner and accurately.

– UHC CP QI is meeting national standards for timeliness of claims payments. Providers are educated on claims standards through provider newsletters and town halls.

• **Prior Authorization (PA) Process**

– UHC CP QI updated its definition of "medical necessity" in its policies and procedures (P&Ps) to include language that supports the opportunity for an enrollee receiving Long-term Services and Supports (LTSS) to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice.

– UHC CP QI has updated its P&Ps to include a description of the processes used to determine and implement LTSS authorization decisions, and how those decisions align with and ensure that the continuity of medically necessary services for LTSS members are provided based on the member's

current needs assessment and person-centered service plan and are reflective of the ongoing needs for these services to avoid disruptions in care.

– P&Ps, the Member Handbook, Care Provider Manual, and Utilization Management (UM) systems were updated to reflect time frames for making expedited authorization decisions within 72 hours instead of three days. This includes processes and updates to UHC CP's UM systems to ensure accurate time tracking of when all requests are received, decisions are rendered on time, and escalation is initiated when nearing the end of the time frame for a decision or to trigger an extension request.

– Planning was initiated in Q3 2019 for the health plan Intake team to train the Clinical Administration team on PA processes and forms requiring completion, including those related to non-clinical PA of inter-island travel. The intent is for this training to be more in-depth compared to previous general overview training, and to level set PA information among internal teams for more consistent and improved provider interactions and education.

– For BH PA processes, in 2019 the ACE Platinum Program was launched to streamline access and improve satisfaction. This program relaxes the PA review process for qualified programs and facilities that meet specific quality outcomes. This includes three inpatient BH facilities and the largest residential treatment program in the State. Providers in the community have expressed frustration in the past with different review requirements across managed care organizations, since not all health plans review the same levels of care. This ACE program is an effort to address any provider abrasion while ensuring quality service delivery.

• **Formulary**

– The UnitedHealthcare Prescription Drug List (PDL), which is updated quarterly, is located on the provider page at the following link: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/hi/pharmacy/HIUHCCP-QUEST-Preferred-Drug-List.pdf

– Starting in July 2019, the drug formulary, or PDL, as well as the quarterly drug updates are posted to the public site at www.UHCCP.com/hi and then from within the member portal as well at www.myuhc.com. These updates allow members to access information on formulary changes that may impact their medications.

– The UHC CP QI Provider Advisory Committee (PAC) reviews the updated PDL and provides input during our quarterly meetings.

• **Adequate Access to Non-Formulary Drugs**

– The Prior Notification Team that processes PAs for non-formulary drugs has transitioned from being a Community & State Entity to an OptumRx operation. This transition occurred on 4/1/19 and is aimed at providing member satisfaction as a result of operational efficiencies. The newly integrated organization will utilize talent and capabilities to build capacity for service levels and turnaround times.

• **Helpfulness of Service Coordinators**

– Throughout 2019, Service Coordination teams received interdepartmental training on key areas related to and affecting providers. Training topics included HEDIS measures; CAHPS; provider and

member incentive programs; NPS and provider satisfaction; compliance; and roles and processes within the Operations department, such as claims, appeals and grievances, member benefits, enrollment, and self-direct services.

– The Service Coordination team will have a table at the Q4 2019 PIE. Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a service coordinator can provide, including care coordination and supporting members with getting needed care.

• **Adequacy of Specialists**

– UHC CP QI works continuously to improve the adequacy of specialists, and we are currently working to expand telehealth options to fill any specialist gaps:

o We are currently working with MDLive to provide direct-to-consumer virtual visits that members access through a Web portal or mobile app. Visits are at no cost to members.

o UHC CP QI continued its contract with Direct Dermatology in 2019 to provide dermatological care to our members through its online platform.

• **Adequacy of Behavioral Health Specialists**

– UHC CP QI works continuously to improve the adequacy of specialists, and we are currently working to expand our telehealth options to fill BH specialist gaps. For example, we are currently working with Genoa Healthcare, a national partner that has providers with Hawai'i licensure, to fill gaps in BH specialists.

• **Availability of Mental Health Providers**

– UHC CP QI uses Express Access and Virtual Visits as a way to have more BH providers available to our members:

o Express Access Network: A network of BH clinicians who have an addendum to their contract agreeing to have appointments available within five days of a member's request for an appointment. Our online directory allows for filtering by clinicians who have this availability. Currently, all participating clinicians are non-prescribers.

o Virtual Visits: We have a network of BH clinicians who have attested to having telehealth capability with technology that has been verified and confirmed to meet our standards.

 The care delivery method and venue can vary—some clinicians provide direct-to consumer care, some provide care to an originating site, and some agencies with locations on multiple islands use virtual visits through internal VCC (virtual circuit connection).

 As an example of virtual visits through an originating site, UHC CP QI collaborated with Paniolo Pediatrics and Family Medicine on Hawai'i Island to provide members with access to BH clinicians through UnitedHealthcare-sponsored computers that were placed in the clinic. Implementation began in Q3 2019.

• Access to Substance Abuse Treatment

– UHC CP QI has an adequate number of Substance Abuse Treatment Centers (SATCs) within its network. However, we understand that the demand for treatment of all levels of care for substance use disorders

(SUD) continues to outpace the availability of treatment services statewide across all health plans. Faced with sharing the same finite network of treatment providers and facilities, UHC CP QI has implemented additional supplemental strategies to improve member access to care and provider and member satisfaction with services:

o BH UM care advocates work closely with inpatient discharge planners to explore SUD treatment options prior to discharge to help facilitate entry into services.

o BH field care advocates also collaborate more readily with treatment programs to help facilitate transportation needs of the member as well as authorization issues with our UM team.

o In 2019, the ACE Platinum Program was launched to streamline access and improve satisfaction. This program relaxes the PA review process for qualified programs and facilities that meet specific quality outcomes. This includes three inpatient BH facilities and the largest residential treatment program in the State.

o Future interventions will include enhancing educational materials to medical providers to highlight SATCs within our network to increase awareness of available options to our members.

‘Ohana Community Care Services (‘Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 Recommendations

Based on ‘Ohana CCS’ data systems and processes, the auditors made one recommendation:

• HSAG recommended that ‘Ohana CCS ensures appropriate Roadmap documentation for supplemental data going forward.

Improvement Activities Implemented

WellCare and Ohana’s HEDIS Team and IT team will ensure close review of each data source submitted in Section 5 and validate applicability to the HI Market prior to submission to ensure accurate Roadmap documentation is provided. Additionally, the QDAR HEDIS Team will run impact reports on each source in advance in order to identify measures that would be affected by each supplemental data source.

2018 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of those ‘Ohana CCS measure rates with comparable benchmarks, two of the measure rates (20.0 percent) ranked at or above the national Medicaid 75th percentile in 2018. An additional five measure rates (50.0 percent) ranked at or above the national Medicaid 50th percentile but below the 75th percentile, indicating moderate performance related to the Behavioral Health domain. Three measure rates (30.0 percent) ranked below the national Medicaid 25th percentile, suggesting opportunities for improvement. HSAG recommends that ‘Ohana CCS focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

• Behavioral Health

– *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*

• Utilization and Health Plan Descriptive Information

– *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

Improvement Activities Implemented

• Behavioral Health—*Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*

– Pharmacy team created an educational flyer for the providers to deliver the information on the best practices for members who are taking antidepressant medication management.

– Pharmacy team also visited BH and PCP offices to discuss the importance of medication adherence with emphasis on antidepressant medication adherence.

– Pharmacy team and Quality department support Community Care Services team with provider trainings annually. Pharmacy team provides education on importance of medication adherence. Quality department also educates providers on all HEDIS measures with emphasis on medication adherence-related measures including antidepressant medication management and importance of member engagement to treatment.

– In late 2018, CCS and Pharmacy Team leveraged existing partnership with 5 Minute Pharmacy, a pharmacy vendor who delivers medication to member's homes or a designated location such as Joint Outreach Center to deliver their medications, if member is homeless, in efforts to remove the identified barriers of transportation or not having an address to get their medications delivered in timely fashion.

– Quality practice advisors have made efforts to connect with all BH providers (psychiatrists, ARNPs, and physician assistants) in the market. Then, QPAs provided an educational flyer specifically on antidepressant medication management for people taking antidepressant medication and provided guidance on best coding practices when billing.

• Utilization and Health Plan Descriptive Information—*Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

– In CCS we hold regular IDTs (Interdisciplinary Team meetings) for the high ER utilizers. Present in those meetings are the BH manager, BH medical director, the BH case management liaison, the QI health plan, the case management agency (including the case manager and team lead), and any other providers as necessary.

– We work with the Queens Coalition for the High ER Utilizers, meeting monthly to discuss treatment plans for the individual members identified as high ER utilizers at Queens.

– If the high ER utilizer is acuity level 5 member, the case is discussed in the daily L5 huddle.

– When notified by the ER that a member is in the ER, the case manager needs to respond to the ER within 1.5 hours to prevent unnecessary hospitalization.

– Case managers follow up with their assigned CCS members within 72 hours after ER visit.

– Pharmacy and CCS team have partnered with 5 Minute Pharmacy to launch a pilot program in efforts to improve the antipsychotic medication adherence by removing identified barriers in accessing medications due to the population being prevalent in homelessness and the severity of the member's mental illness. The team determined that the pilot program will be launched for acuity level 5 members, who are identified to be more severe in their behavioral health conditions among the CCS population and needing medication such as long-acting injectable antipsychotic medication in a timely fashion to prevent acute schizophrenic episodes or visits to the ER as a way to access needed medication. If the outcome of the pilot program is identified to be successful, the team plans to expand the program to all FQHC pharmacies with CCS members assigned to them, who are needing the same or similar antipsychotic medication.

2019 – 2020 Hawaii MQD Health Plan Initiatives for 2020 CMS Annual Report

Assessment of Follow-Up to Prior Year Recommendation

This is an assessment of how effectively the QUEST Integration health plans addressed the improvement recommendations made by HSAG in the prior year (2019) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The CCS program members were not separately sampled for the CAHPS survey as they were included in the QI health plans' sampling; therefore, there are not separate CAHPS results related to CCS members.

Except for the compliance monitoring section and PIPs, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to identify the degree to which the health plans' initiatives were responsive to the improvement opportunities. Plan responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Compliance Monitoring Review

Formal follow-up re-evaluations of the health plans' corrective actions to address the deficiencies identified in the 2019 compliance reviews were all carried over to 2020. The specific compliance review findings and recommendations were reported in the 2020 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance. All QI health plans and 'Ohana CCS were found to have sufficiently addressed and corrected their findings of deficiencies through implementation of CAPs and were found to be in full compliance with requirements by March 2020. In July 2020, HSAG performed a desk review of documents, file reviews, and a virtual site visit that included reviewing additional documents and conducting interviews with QUEST Integration's Health Plans and 'Ohana CCS key staff members. In addition, QI health plans and 'Ohana CCS provided demonstrations of various health information systems and applications used to conduct health plan operations. HSAG evaluated the degree to which all QI health plans and 'Ohana CCS complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to eight selected standard areas:

- The health plan's policies, procedures, and processes related to its selection of providers.
- The health plan's policies, procedures, contracts, and processes related to its subcontracts and any delegation of its managed care functions.
- The health plan's policies, procedures, and processes for credentialing and recredentialing its individual practitioners and organizational providers.
- The health plan's procedures and structure for its quality assessment and performance improvement (QAPI) program.
- The health plan's systems and mechanisms for protecting the confidentiality of health information and collecting, analyzing, and reporting healthcare data and information on its members and services.
- The health plan's adoption and use of clinical practice guidelines.
- The health plan's policies, procedures, and processes related to the management of compliance and fraud, waste, and abuse (FWA) programs.
- The health plan's policies, procedures, and processes related to enrollment and disenrollment of members.

Performance Improvement Projects

In alignment with the rapid-cycle PIP process, recommendations are made at the submission of each PIP module. The health plans successfully completed Module 1 and Module 2 and designed a methodologically sound project for each PIPs. The health plans also successfully completed Module 3 and identified opportunities for improvement. Health plans further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. Health plans have also initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for each PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

AlohaCare Quest Integration (AlohaCare QI)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

AlohaCare's policy for provider network adequacy and selection and provider agreement template confirmed that AlohaCare had a comprehensive process for the selection of its network providers to sufficiently meet the needs of AlohaCare's QI members.

AlohaCare's documents demonstrated that AlohaCare communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to participate in treatment decisions. AlohaCare staff members confirmed during the virtual site review interview discussion that it did not object to providing any of its services based on moral or religious grounds, and that effective processes were in place to address situations in which providers may express such objections and ensure members obtain an alternative provider.

AlohaCare's Provider Education policy outlined the expectations and process for delivering timely education to participating providers about health plan operations, managed care, and program requirements. Providers had open access to provider trainings through AlohaCare's online provider portal for on-demand training and ease of access to the provider manual. Bi-annual group training events were offered to providers that addressed plan requirements, important updates, and various topics, including but not limited to claim submissions and billing requirements; member rights and responsibilities; service coordination access and availability; and primary care provider (PCP) roles and responsibilities.

Areas Requiring Improvement

While the Credentialing and Recredentialing Processes policy identified that a practitioner is notified of the reason(s) for denial of panel membership and notified of his or her right and process to appeal the decision, the policy did not include that affected providers receive written notice of the reason for the health plan's decision at least 30 days prior to the effective date and notification to DHS at least 45 days

prior to the effective date if the individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

Standard II—Subcontracts and Delegation

Strengths

AlohaCare had subcontracts for delegation of peer review for utilization management (UM) and quality issues to Allmed HealthCare Management, nurse advice call line to CareNet Health, pharmacy benefits management to Express Scripts, foreign language/translation services to Language Services Associates, satisfaction surveys to Market Trends Pacific, and answering services to Physicians Exchange. AlohaCare also had delegation agreements with several community case management agencies (CCMAs) for service coordination to members receiving long-term services and supports (LTSS) in community care foster family homes (CCFFH) and expanded adult residential care homes (E-ARCH). (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Template delegation agreements and a sample of executed subcontracts submitted were reviewed to ensure all required provisions were included. AlohaCare had policies and procedures for monitoring, oversight, and evaluation of its delegated entities. The health plan provided evidence of having conducted annual audits of its delegates reviewed under this standard. For those delegates, AlohaCare provided evidence of ongoing monitoring, which included regular review of reports from delegates and evaluation of performance using an oversight dashboard and tracking spreadsheet.

The Delegation Oversight policy addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with MQD.

Areas Requiring Improvement

The Allmed HealthCare Management contract, Carenet Health contract, and one executed CCMA (Blue Water Resources) delegation contract was selected for review to ensure all required contract provisions were present. The delegation agreement for Blue Water Resources included all required contract provisions. The Allmed HealthCare Management contract also included all required contract provisions; however, the medical record retention requirements were inconsistent. The Medicare Program Exhibit required retention of records for 10 years, but the Medicaid Program Exhibit required retention of records for seven years. The Carenet Health contract required fiscal records be retained for 10 years but required medical records be retained for only seven years.

AlohaCare must amend its current agreements with Allmed HealthCare Management and Carenet Health or develop an additional contract or written agreement to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

AlohaCare must ensure that mechanisms are in place to provide written notice of the reason for the health plan's decision to decline an individual or groups of providers in its network to affected providers at least 30 days prior to the effective date and notify DHS at least 45 days prior to the effective date if

the individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

Standard III—Credentialing

Strengths

AlohaCare demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual licensed practitioners that effectively evaluated practitioners and complied with the National Committee for Quality Assurance (NCQA) credentialing standards and guidelines. A desk review of 10 credentialing files and 10 recredentialing files revealed that timely primary source verification of credentials, timely recredentialing, and timely exclusion searches using the NCQA-approved databases were performed. Further, the health plan's credentialing and recredentialing files reviewed verified that staff members obtained completed ownership and disclosure documents during credentialing and recredentialing as required. Practitioner credentialing and recredentialing applications contained all required information and confirmed that AlohaCare maintained comprehensive and well-organized credentialing and recredentialing files.

Although AlohaCare did not delegate credentialing functions during the look-back period, the health plan maintained a Delegation Oversight policy and processes for pre-delegation assessment, ongoing monitoring and oversight, as well as annual evaluation of its delegates.

A file review of five organizational providers for initial assessment and five organizational providers for reassessment confirmed that AlohaCare followed its policies and NCQA guidelines for the assessment of organizational providers. Specifically, for non-accredited providers, AlohaCare's processes assured that an on-site quality assessment was performed or that, in lieu of a site visit, AlohaCare substituted a Centers for Medicare & Medicaid Services (CMS), State, or other sanctioned entity's quality review that was determined to meet the health plan's quality assessment criteria.

The Credentialing Committee minutes verified AlohaCare's process for medical director sign-off on clean files, peer review of files not meeting guidelines, and the medical director's participation in the credentialing program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard IV—Quality Assessment and Performance Improvement

Strengths

The AlohaCare QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision making to improve organizational functions, structures, and processes to improve QI member outcomes.

As required by its MQD contract, AlohaCare maintained a Hawaii-licensed physician (Chief Medical Officer [CMO]) responsible for clinical oversight, implementation, and evaluation of the quality improvement program and who chairs the Corporate Quality Improvement Committee (CQIC). Additionally, a behavioral health medical director (a Board-certified Psychiatrist with unrestricted license to practice medicine in Hawaii) provided support and overall oversight of behavioral health aspects of the quality improvement program and is a member of the CQIC.

The health plan's comprehensive quality improvement program description included its QAPI program mission and purpose, organizational structure, governance, and committee structure. Subcommittees and work groups appointed by the CQIC also provided input to the health plan's quality improvement program. AlohaCare also included as part of the overall scope of its QAPI program the goal to improve members' health status through a variety of activities implemented across all care settings. The overarching goals outlined in QAPI program description were to improve quality of care delivered and quality of services provided, while promoting safe clinical practices. The annual QAPI work plan described improvement activities that included major objectives, planned activities, regulatory requirement, reporting methods, identification of responsible individuals or groups, and time frames for completion. The work plan also functioned as the basis for the health plan's annual evaluation of its QAPI program.

The AlohaCare UM program description, policies and procedures, and UM work plan demonstrated the health plan's ongoing monitoring of its service utilization patterns and detection of over- and underutilization.

The CQIC minutes and interview discussion with AlohaCare staff members during the virtual review interview discussion confirmed that the health plan used data reports, tracking, and trending findings in its overall QAPI program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

AlohaCare provided presentations, data and process flow diagrams, and a system demonstration of its information systems, which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. AlohaCare also had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. AlohaCare also contracted with Zelis Healthcare to submit claims through its Payment Integrity system, which applies enhanced claim edits and high-dollar bill review processes. The health plan implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

AlohaCare had data security measures, policies, and plans related to disaster planning and recovery and business continuity. The health plan conducts an annual Business Impact Analysis (BIA) and risk Assessment (RA) to identify the critical systems to ensure recovery of those systems occurs within 24 hours of a disruption. AlohaCare had several policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed, acquired, or disclosed as a result of a breach. The health plan required all employees to complete privacy and security training at the time of hire and annually thereafter. During the virtual site review, AlohaCare confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

AlohaCare's policy on adoption and dissemination of clinical practice guidelines (CPGs) described practices for selecting CPGs that are based on valid, reliable clinical evidence or consensus of healthcare professionals; are relevant to its enrolled membership; adopted in consultation with contracting healthcare professionals; and reviewed and updated at least annually. As part of AlohaCare's process for the adoption of CPGs, AlohaCare's Practitioners Advisory Committee (PAC), whose membership includes participating practitioners the health plan's network, is responsible for the review of new guidelines as well as suggested updates of existing guidelines, as deemed appropriate to be presented to the PAC. Recommended guidelines are reported to the CQIC by the CMO for approval of the adoption. Further, the guidelines supported quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. The process for the selection, adoption, dissemination, and implementation of CPGs was also integrated into the QAPI program.

AlohaCare had a variety of CPGs for medical conditions, behavioral health, and preventive care that included diabetes, chronic obstructive pulmonary disease (COPD), diagnosis and treatment management of attention deficit/hyperactivity disorder (ADHD) in school aged children, and adult preventive health. AlohaCare received weekly emails from the National Guideline Clearinghouse to assure timely receipt of summaries of new and revised practice guidelines.

The health plan had processes for regular dissemination of CPG information to providers, including the use of links to AlohaCare's website portal, provider manual, or through the Ku'i Ka Lono quarterly provider newsletters. Members were informed of how to access CPGs through information provided in the annual member information bulletin.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

AlohaCare had a compliance plan and several policies and procedures that guided the health plan's compliance program. AlohaCare provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. AlohaCare's Compliance Officer had a direct reporting line to the Chief Executive Officer and the Board of Directors and was charged with identifying, tracking, mitigating, and reporting on operational compliance risks and conducting day-to-day compliance activities.

AlohaCare utilized Compliance 360, an application for tracking and reporting compliance activities and FWA investigations. AlohaCare implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. The health plan used several FWA detection methodologies including focused medical reviews to detect provider outliers and variations, claims monitoring, trending, and analysis reporting and monitoring that included rapid disenrollment statistics and complaint and grievance statistics. AlohaCare also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members. AlohaCare contracted with HealthLogix as its vendor for mailing of the VOS statements.

If AlohaCare became aware of or identified any potential FWA, the health plan notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the State, AlohaCare had a standard operating procedure (SOP) to enable edits in QNXT, its claims processing application, to suspend payments to providers upon notification from the State.

AlohaCare had processes in place to report overpayments due to FWA promptly using the State's Suspected Fraud Waste and Abuse (SFA) reporting tool, quarterly using the State's Fraud Waste and Abuse Summary Report (FAS) template, and annually using the State's Overpayment Report template. AlohaCare also had a policy and procedure in place to notify the State's financial office in the event it received an overpayment of its capitation.

AlohaCare had a mechanism in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that AlohaCare became aware of a change in a network provider's circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, AlohaCare notified the State using the Provider Suspension and Termination report. Utilizing the AlohaCare provider manual and participating provider agreements, AlohaCare informed providers of their requirement to report overpayments to the health plan, return the overpayment within 60 days, and notify the health plan in writing of the reason for the overpayment.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VIII—Enrollment and Disenrollment

Strengths

AlohaCare had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. The health plan demonstrated its processes for accepting the daily eligibility file

from the State and loading the file into QNXT, where new member records would be created and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the health plan data and the State eligibility file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, AlohaCare customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. AlohaCare did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

AlohaCare had a non-discrimination policy and a notice to members to inform enrolled members that AlohaCare does not discriminate against members or use any policy or practice that has the effect of discriminating against members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

HMSA Quest Integration (HMSA QI)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

HMSA's policy for provider selection, retention, and recruitment confirmed that HMSA had a comprehensive process for the selection of its network providers to sufficiently meet the needs of HMSA's QI members.

HMSA's documents demonstrated that HMSA communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to participate in treatment decisions. HMSA confirmed during the virtual site review that it did not object to providing any of its services based on moral or religious grounds, and that HMSA had effective processes to address situations in which providers may express such objections and ensure members obtain an alternative provider.

HMSA's provider training program informed providers about health plan operations, managed care, member rights and responsibilities, service coordination, claims, and utilization management (UM). Providers had open access to provider trainings through HMSA's Provider Resource Center, a website portal, or through scheduled webinars. Additionally, the HMSA Provider Resource Center housed a provider library that included HMSA policies, formularies, clinical practice guidelines (CPGs), care management programs, and payment and billing information.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard II—Subcontracts and Delegation

Strengths

HMSA had subcontracts for delegation of behavioral healthcare service coordination and UM to Beacon Health Options, Inc.; 24-hour nurse line call center services to Carenet Health; claims processing for providers to Cobalt Health, Inc.; pharmacy benefits management, specialty drug services, and credentialing of contracted pharmacies to CVS Caremark; physical and occupational therapy to eviCore; walk-in clinic services and credentialing of clinical staff members to MinuteClinic; and radiology, pain management, and UM to National Imaging Associates (NIA). HMSA also reported subcontracts with several community case management agencies (CCMAs) for service coordination to members receiving long-term services and supports (LTSS) in community care foster family homes (CCFFH) and expanded adult residential care homes (E-ARCH). (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Subcontracts submitted for this standard included all required provisions. HMSA provided evidence of having conducted annual audits of its delegates reviewed under this standard. For those delegates, HMSA provided evidence of ongoing monitoring, which included regular review of reports from delegates and the use of a vendor scorecard to monitor performance. HMSA utilized ServiceNow, a vendor management tool, to store delegate contracts, track performance, review scorecards and operational deliverables, and track delegate audit dates.

HMSA's template delegate contracts and QUEST Subcontractor Process Diagram addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with the MQD.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard III—Credentialing

Strengths

HMSA demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual providers that effectively evaluated providers and complied with the National Committee for Quality Assurance (NCQA) credentialing standards and guidelines. A review of 10 credentialing files and 10 recredentialing files demonstrated that HMSA implemented its policy and processes.

HMSA provided evidence that credentialing delegate agreements:

- Described the delegated activities and the responsibilities of HMSA and the delegated entity.
- Required monthly and quarterly reporting of the delegated entity to HMSA.
- Described the process by which HMSA evaluated the delegated entity's performance.

• Specified that HMSA has overall rights and authority to approve, suspend, and terminate individual and organizational providers.

• Described HMSA's process for remediation should the delegated entity not fulfill its obligations, including revocation of the delegation agreement.

The files reviewed confirmed that HMSA and its delegates conducted primary source verification of practitioners' credentials and conducted searches of federal exclusion databases to ensure that practitioners and providers were eligible for participation in federal healthcare programs. HMSA also provided evidence of tracking and ensuring that providers completed and submitted ownership and disclosure documents at initial credentialing and recredentialing.

HMSA provided evidence that it monitored its delegates by regularly reviewing monthly and quarterly reports and completing annual delegation audits.

Areas Requiring Improvement

While HMSA had a policy and processes in place for assessment and re-assessment of organizational providers that included a requirement for providers to submit a completed application, one of the five assessment of organizational files and one of the five re-assessment of organizational files reviewed did not include a completed application as required by HMSA's policy. HMSA staff members provided copies of follow-up letters sent to both providers requesting additional documents; however, a request for a completed application was not included in the letter. It was unclear based on the file documentation whether additional efforts were made to obtain a completed application.

Standard IV—Quality Assessment and Performance Improvement

Strengths

The HMSA QAPI program was supported by comprehensive plans and numerous policies that guided the health plan's care and service delivery system. The documents also provided the framework through which monitoring and improvement activities were conducted.

HMSA annually prepared a QAPI program description, a QAPI work plan, and QAPI program evaluation of the previous year's quality improvement program accomplishments. The quality management (QM) program description was inclusive of all member populations; identified the scope of covered services/settings; and outlined the QM committee structure, the role of the health information system, quality improvement interventions, mechanisms for identification of members with special health care needs (SHCN), and the use of CPGs, among other areas of focus. The health plan also provided its UM program description and UM work plan as evidence of HMSA's ongoing monitoring of service utilization patterns and detection of over- and underutilization.

The robust QAPI work plan incorporated measurable goals, time frames, previously identified issues, and responsible staff members assigned to each quality improvement project. Further, the work plan served as the basis for the health plan's annual QAPI program evaluation. The annual evaluation validated the health plan's use of data, trending, and measurement against established goals, and included a narrative discussion of the health plan's accomplishments and any identified barriers that hindered goal achievement. Quality Improvement Committee meeting minutes demonstrated the

health plan's regular review of performance, reporting of metrics, and overall compliance with the work plan.

Additionally, review of the Utilization Management Committee and Case Management Committee meeting minutes and virtual site review interview discussion provided further evidence that the health plan used data trending and analysis in its overall quality improvement program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

HMSA provided presentations, data and process flow diagrams, and system demonstration of its information systems, which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. HMSA also had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The health plan implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

HMSA had data security measures, policies, and plans related to disaster planning and recovery and business continuity. The health plan conducts an annual Service Recovery Exercise (SRE) to ensure that the data recovery processes it implements are working as expected. HMSA had several policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed, acquired, or disclosed as a result of a breach. The health plan required all employees to complete privacy and security training at the time of hire and annually thereafter. During the virtual site review, HMSA confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

HMSA's policy on adoption and dissemination of CPGs described practices for selecting CPGs that are based on valid, reliable clinical evidence or consensus of healthcare professionals; are relevant to its enrolled membership; adopted in consultation with contracting healthcare professionals; and reviewed and updated at least annually. Quality Improvement Operations Committee minutes confirmed HMSA annually reviewed and updated its CPG policy.

The HMSA Provider Resource Center Library posted numerous CPGs for preventative health, behavioral health, and medical conditions, which included Attention Deficit Hyperactivity Disorder, Cardiovascular

Disease and Stroke—Primary Prevention, Evaluation and Management of Chronic Kidney Disease, Rheumatoid Arthritis, and Primary Preventative Service—Children (Perinatal–19 Years). HMSA disseminated CPGs to its participating providers through special mailings, updates to the provider manual, or other communications. CPGs were made available to providers via the HMSA Provider Resource Center Library. HMSA had processes in place to distribute the CPGs to members through regular member communications, mailings, or upon member's request.

During the virtual site review interview discussion, HMSA staff members confirmed that the health plan conducts interrater reliability testing and physician peer-to-peer consultation at least quarterly to assure CPGs align with service delivery.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

HMSA had a compliance plan and several policies and procedures that guided the health plan's compliance program. HMSA provided initial onboarding and annual training to employees, executives, and board members about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security.

HMSA utilized Compliance 360, an application for tracking and reporting of compliance activities and FWA investigations. HMSA implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. HMSA's Special Investigation Unit (SIU) utilized software specifically designed for fraud detection and analysis in conjunction with other programs used for data mining, analysis, and reporting. The SIU performed proactive claims analysis and peer comparison of provider claims billing patterns to identify outliers. HMSA also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members.

If HMSA became aware of or identified any potential FWA, the health plan notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the State, HMSA had procedures to enable edits in QNXT, its claims processing application, to suspend payments to providers upon notification from the State.

The health plan had processes in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that HMSA became aware of a change in a network provider's circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, HMSA notified the State using the Provider Suspension and Termination Report. Utilizing provider contracts and the Provider Resource Center on its website, HMSA informed providers of their requirement to report overpayments to the health plan, return the overpayment within 60 days, and notify the health plan in writing of the reason for the overpayment.

Areas Requiring Improvement

HMSA had processes in place to report overpayments due to FWA promptly using the State's Suspected Fraud Waste and Abuse (SFA) reporting tool, quarterly using the State's Fraud Waste and Abuse Summary Report (FAS) template, and annually using the State's Overpayment Report template. While HMSA could speak to a general process for reconciling capitation payments from the State against eligibility files, it did not have any written policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

HMSA must develop and implement a written policy, procedure, and/or process to ensure that the health plan and subcontractors report to the State within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

Standard VIII—Enrollment and Disenrollment

Strengths

HMSA had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. The health plan demonstrated its processes for accepting the daily eligibility file from the State and loading the file into its claims system, QNXT, where new member records would be created, and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the health plan data and the State eligibility file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, HMSA customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. HMSA did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

HMSA had a non-discrimination policy and a notice to members to inform enrolled members that HMSA does not discriminate against members or use any policy or practice that has the effect of discriminating against members.

Areas Requiring Improvement

There were no required corrective actions for this standard

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

The Health Care Services Agreement Template and Hawaii Permanente Medical Group Employment Agreement Template demonstrated that KFHP communicated and supported providers to advise and

advocate for members regarding members health status, medical care, treatment options, and the right to participate in treatment decisions. KFHP confirmed during the virtual site review interview discussion that it did not object to providing any of its services based on moral or religious grounds and that KFHP had processes to address situations in which providers may express such objections and ensure members obtain an alternative provider.

KFHP's provider manual and Provider Education policy identified the processes to ensure providers are informed and educated about health plan operations, organizational structure, QUEST Integration benefit packages, grievance and appeal processes, disease management, and other member programs. Further, the Provider Education policy defined the protocols for delivery of educational sessions at time of contracting; as part of new hire orientation; annual check-in; semi-annual updates; and individual meetings, in an effort to support continuous communication and education on pertinent topics.

KFHP conducted monthly training for affiliated providers that included such topics as billing and claims procedures. Additionally, an overview of Office Ally Direct Data Entry Solution, a full-service clearinghouse for online claims entry, is offered as part of KFHP's provider training/education program. The onboarding of Hawaii Permanente Medical Group (HPMG) providers was found to be comprehensive and communicated important information about the QUEST Integration program, service delivery, documentation and reporting requirements, and member rights and responsibilities.

Areas Requiring Improvement

The Credentialing and Privileging Policy and Procedure identified that the health plan would promptly notify the applicant in writing no later than within 30 calendar days of the actions taken on behalf of Kaiser Permanente Hawaii (KPHI) to decline participation in its provider network. The policy, however, did not identify that the health plan notifies DHS at least 45 days prior to the effective date if the individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital. The health plan must ensure that its policy includes the required time frames for notification to DHS should the health plan decline individuals or providers that represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

Standard II—Subcontracts and Delegation

Strengths

KFHP had subcontracts for delegation of provider network development and management, utilization management (UM), and professional services to HPMG; pharmacy benefit management to MedImpact; and service coordination to members receiving long-term services and supports (LTSS) in community care foster family homes (CCFFH) and expanded adult residential care homes (E-ARCH) to several community case management agencies (CCMAs). (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

KFHP's policies and delegation agreements ensured that the health plan maintained ultimate responsibility for adhering to and complying with its contract with the State. KFHP's delegation agreement with HPMG was amended in 2019 and contained all required subcontractor provisions.

KFHP provided evidence of participating in ongoing monitoring of MedImpact, which included the review of reports and participation of national oversight meetings held quarterly, identification of any

deficiencies and implementation of corrective action procedures, as well as the completion of an annual formal audit done at the national level.

KFHP's policies and procedures addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with the MQD.

Areas Requiring Improvement

KFHP did not have a policy, procedure, or process for conducting a pre-delegation evaluation of a potential subcontractor prior to executing a delegation agreement. The health plan also did not have a policy, procedure, or process for conducting ongoing monitoring and formal reviews of HPMG or the CCMAs, although the health plan did provide some evidence of monitoring its delegates' performance. As evidence of oversight of HPMG, KFHP provided various documents such as GeoAccess reports, grievance and appeal reports, and UM reports; however, it was unclear how often this information was obtained and how this information was utilized by KFHP to ensure HPMG was performing the delegated activities as expected. In addition, there was no documentation of KFHP conducting a formal review of HPMG.

As evidence of oversight of the CCMAs, KFHP provided a Desktop Audit Tool that was completed on one CCMA in 2018. The tool was limited and did not include elements related to the CCMA's delegated functions. KFHP also submitted a Case Management Agency Desktop Review Tool that appeared to be newly created, not finalized, and not implemented. During the interview, KFHP staff members stated that they currently did not have a process to report formal audit results to the CCMAs, nor a corrective action plan process in the event deficiencies were found during ongoing monitoring or formal review.

KFHP must develop and implement:

- A policy, procedure, or process to evaluate a subcontractor's ability to perform the activities to be delegated prior to the execution of a delegation agreement.
- A policy, procedure, or process to conduct ongoing monitoring and formal review of its delegates. This should include designation of the employees/departments responsible for conducting the delegation oversight activities, the frequency of ongoing monitoring (e.g., quarterly review of reports, monthly oversight meetings) and formal reviews, processes used to evaluate performance (e.g., scorecards, metrics), processes for conducting formal review of delegates (e.g., elements of the review, scoring, reporting of results), processes for scheduling and tracking timeliness of formal reviews, and a corrective action process.

Upon review of the CCMA contracts and through discussions with health plan staff members during the virtual site review, it was evident that KFHP did not differentiate between the CCMAs' service provision and the CCMAs' delegated responsibilities. KFHP stated it sent a letter to the CCMAs in January 2020 intending to modify the current Health Care Services Agreements to delegation agreements. However, the letter did not specify the delegated activities and related reporting responsibilities; it revised and reinforced the provider responsibilities outlined in the original Health Care Services Agreement. Section 2.11 of the Health Care Services Agreement stated that, if KFHP delegated activities to the provider,

such delegated activities would be described in a separate written agreement and signed by the parties. KFHP did not provide any separate written and signed delegation agreements for review.

While the current CCMA contracts contained some of the required provisions, several required provisions were missing or inconsistent with the health plan's contract with the State. For example, notification to the health plan and the MQD of breaches of confidential information was present in some contracts but not all. Also, the specific medical record requirements and retention policies were not in compliance with the State contract. The contracts contained varying record retention requirements including six, seven, and 10 years.

KFHP must amend its current agreements with the CCMAs or develop an additional contract or written agreement to:

- Specify the managed care administrative functions and obligations being delegated (e.g., completion of the initial health and functional assessment (HFA), submission of the 1147) and the timelines and the health plan's expectations for conducting the delegated activities.
- Specify the reporting responsibilities associated with the delegated tasks (e.g., monthly member roster, member hospitalizations for the month, date of face-to-face visit with member).
- Specify that the CCMA agrees to perform the delegated activities and reporting responsibilities specified in compliance with the health plan's contract obligations.
- Include the provision that the State, the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees will have the right to audit the subcontractor through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Include a provision that allows the health plan to evaluate the subcontractor's ability to perform the activities to be delegated.
- Include a provision that the CCMA notify the health plan and the MQD of all breaches of confidential information related to Medicaid applicants and recipients, and as health plan members. The CCMA must notify the MQD within two business days of discovery of the breach and provide a written report of the investigation and resultant mitigation of the breach within 30 business days of discovery.
- Specify the medical record requirements and retention policy in compliance with the State's health plan contract (10 years).

KFHP's MedImpact Service Agreement did not include a provision that allows the health plan to evaluate the subcontractor's ability to perform the activities to be delegated; that the right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; the requirement that the subcontractor fulfill the requirements of 42 CFR §438.6; and medical record retention policies in compliance with the State's health plan contract.

KFHP must amend its current agreement with MedImpact or develop an additional contract or written agreement to:

- Include a provision that allows the health plan to evaluate the subcontractor's ability to perform the activities to be delegated.
- Include the provision that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees will have the right to audit the subcontractor through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Require the subcontractor fulfill the requirements of 42 CFR §438.6 (special contract provisions related to payment) that are appropriate to the service delegated under the subcontract.
- Include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

Standard III—Credentialing

Strengths

KFHP's Credentialing and Privileging Policy and Procedure described the processes for credentialing and recredentialing licensed independent practitioners and allied health practitioners that aligned with the National Committee for Quality Assurance (NCQA) standards and guidelines.

A desk review of 10 individual practitioner credentialing and 10 individual practitioner recredentialing files revealed timely primary source verification of all credentials, recredentialing, and exclusion searches using NCQA-approved databases. During the virtual site review interview discussion, KFHP staff members confirmed the health plan's practice for obtaining completed ownership and disclosure documents from providers and practitioners at the time of credentialing and recredentialing.

Review of credentialing committee meeting minutes verified that KFHP followed the health plan's peer review process for review of files not meeting established criteria, and the process for ensuring nondiscriminatory credentialing and recredentialing decisions.

Areas Requiring Improvement

A review of the assessment and re-assessment of organizational provider files revealed that the health plan did not collect the CMS or Hawaii State Department of Health (DOH) quality review report as required in the health plan's policy in three of the five assessment of organizational providers and two of the five re-assessment of organizational provider files, as specified in KFHP's Credentialing and Privileging Policy and Procedure. During the virtual review interview session, KFHP staff members identified that the health plan currently receives the complete quality review report only if adverse findings are noted during the time of the CMS or DOH review. KFHP staff members confirmed that site reviews conducted by other entities, such as Community Ties of America (CTA), were not reviewed by the health plan to determine if the results met the health plan's quality guidelines.

The health plan must develop a mechanism to ensure that State or CMS surveys are received and meet KFHP's quality guidelines for assessments or re-assessments of organizational providers that are not accredited and are conducted in lieu of KFHP conducting the on-site review.

Standard IV—Quality Assessment and Performance Improvement

Strengths

The KFHP QAPI program was supported by both national and regional quality structures, comprehensive plans, and numerous policies that guided the health plan's care and service delivery system. The documents also provided the framework through which monitoring and improvement activities were conducted. KFHP had an established integrated quality program wherein quality assurance and systems improvement are shared responsibilities of KFHP, Kaiser Health Foundation (KFH), and HPMG. The Hawaii Region Quality Program was designed as a systematic, integrated, widely deployed approach to planning, implementing, assessing, and improving clinical quality, patient safety, health outcomes, resource management/stewardship, clinical risk management, outside services, and service performance.

KFHP annually prepared a quality management (QM) program description, a QM work plan, and QM program evaluation of the previous year's quality program accomplishments. The QM program description was inclusive of all member populations; identified the scope of covered services/settings; and outlined the QM committee structure, the role of the health information system, quality improvement interventions, mechanisms for identification of members with special health care needs (SHCN), and the use of clinical practice guidelines (CPGs), among other areas of focus. The health plan also provided its UM program description and UM work plan as evidence of KFHP's ongoing monitoring of service utilization patterns and detection of over- and underutilization.

The robust QAPI work plan incorporated measurable goals, time frames, measurement source, and responsible staff members assigned to each quality improvement objective. Further, the work plan served as the basis for the health plan's annual QAPI program evaluation. The annual evaluation validated the health plan's use of data, trending, and measurement against established goals, and included the health plan's accomplishments and any identified barriers/challenges that hindered goal achievement.

All clinical care provided by KFHP is documented and delivered using an integrated electronic medical record (KP HealthConnect). This system interfaces with pharmacy, laboratory, and diagnostic imaging systems to provide real-time data for all patients. To support population-based primary and secondary preventive care, the Hawaii Region developed a chronic disease and patient-based decision-support system. Use of this tool allows the primary care physician to closely monitor chronic disease members' progress in meeting specified quality goals for disease management.

QM committee meeting minutes demonstrated the health plan's regular review of performance, reporting of metrics, data trending and analysis, and overall compliance with the QAPI work plan and quality improvement program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

KFHP provided presentations, data and process flow diagrams, and a system demonstration of its information systems, which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. KFHP also had processes in place to verify the accuracy and completeness of its claims and encounter data by running the data through various system edits within its claims systems and implementing the National Medicaid Encounter Data Reporting System in 2019. The health plan implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

With the assistance of local, regional, and national information technology departments, KFHP implemented several data security measures and policies and plans related to disaster planning and recovery and business continuity. KFHP had policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed, acquired, or disclosed as a result of a breach. The health plan required all employees to complete privacy and security training at the time of hire and annually thereafter. During the virtual site review, KFHP confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

KFHP adopted both national-level and Hawaii Region CPGs. Topics included medical and behavioral health conditions, as well as preventive healthcare guidelines for adults and children. The process for selection, adoption, dissemination, and implementation of CPGs was described in policies and procedures and was incorporated into the program descriptions for both quality and UM.

KFHP’s CPG policies and procedures described practices for selecting CPGs that are based on valid, reliable clinical evidence or consensus of healthcare professionals; are relevant to its enrolled membership; adopted in consultation with contracting healthcare professionals; and reviewed and updated at least every two years.

The health plan had processes for regular dissemination of CPG information to providers, including use of the KPHI internal Clinical Library Hawaii Guidelines intranet site, distribution of new or revised guidelines to affiliated practitioners via the HI Affiliate Practitioner Manual site, or through internal and external affiliate practitioner newsletters. Members are informed of how to access CPGs through information provided in the member handbook. Dissemination of CPGs to members occurs upon request through KFHP’s customer service center.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

KFHP had a compliance plan and several policies and procedures that guided the health plan's compliance program. KFHP provided initial onboarding and annual training to employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. KFHP's compliance officer was responsible for leading the quarterly compliance committee meetings, partnering with the HPMG compliance officer, performing day-to-day compliance activities, and reporting compliance matters directly to the Plan President.

KFHP utilized CaseTrack, a case monitoring system for tracking and reporting compliance activities and FWA investigations. KFHP implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. Kaiser Permanente's National Fraud Control Unit supported KFHP's monitoring efforts by utilizing software specifically designed for fraud detection and analysis in conjunction with other programs used for data mining, analysis, and reporting. KFHP also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members.

If KFHP became aware of or identified any potential FWA, the health plan notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the State, KFHP had procedures to enable edits in Tapestry, its claims processing application, to suspend payments to providers upon notification from the State.

The health plan had processes in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that KFHP became aware of a change in a network provider's circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, KFHP notified the State using the Provider/Employee Integrity and Education Reporting Tool.

Areas Requiring Improvement

KFHP had processes in place to report overpayments due to FWA promptly using the State's Suspected Fraud Waste and Abuse (SFA) reporting tool, quarterly using the State's Fraud Waste and Abuse Summary Report (FAS) template, and annually using the State's Overpayment Report template. While KFHP could speak to a general process for reconciling capitation payments from the State against eligibility files, it did not have any written policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

KFHP must develop and implement a written policy, procedure, and/or process to ensure that the health plan and subcontractors report to the State within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

KFHP's Health Care Services Agreement for providers stated that the "provider shall be required to refund any payment from a member or member's family (in excess of member's share of cost) for the prior coverage period" and "require the provider to report capitation payments or other overpayments

in excess of amounts specified in the contract within sixty (60) calendar days when identified." The agreement did not include information about how or to whom the provider reports overpayments, how the provider returns the overpayment, nor the requirement that the provider is to notify the health plan in writing the reason for the overpayment. The KFHP QUEST Integration Provider Manual contained no information regarding overpayments.

KFHP must amend its Health Care Services Agreement, revise the provider manual, or implement some other mechanism to inform providers of the requirement to report overpayments to the health plan, how to return the overpayment, the requirement to return the overpayment within 60 days, and notify the health plan in writing the reason for the overpayment.

Standard VIII—Enrollment and Disenrollment

Strengths

KFHP had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. The health plan demonstrated its processes for accepting the daily eligibility file from the State and loading the file into its Common Membership System where new member records would be created, and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the health plan data and the State eligibility file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, KFHP customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. KFHP did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas Requiring Improvement

There were no required corrective actions for this standard.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

UHC CP's policies and procedures, provider agreement appendix template, and its care provider manual confirmed that UHC CP had a comprehensive process for the selection of its network providers. UHC CP documents demonstrated that UHC CP communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to participate in treatment decisions. UHC CP confirmed that it did not object to providing any of its services based on moral or religious grounds, and the health plan had effective processes to address

situations in which providers may express such objections and ensure members obtain an alternative provider.

UHC CP's large-scale training and provider Town Hall presentations were comprehensive and informed providers about health plan operations, managed care, claims, and utilization management (UM). Additionally, UHC CP provided access to its on-demand training platform, UHC OnAir, which offered provider education on various topics, some which included continuing education credits.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard II—Subcontracts and Delegation

Strengths

UHC CP had subcontracts for delegation of behavioral healthcare coordination, behavioral health (BH) provider network development and management, and BH provider credentialing to OptumHealth (Behavioral Health); 24-hour nurse line call center services to OptumHealth (Nurseline); and pharmacy network management, pharmacy benefit management, and pharmacy claims management to OptumRx. UHC CP also reported subcontracts with LogistiCare for nonemergent transportation and various community case management agencies (CCMAs) for service coordination to members receiving long-term services and supports in community care foster family homes (CCFFH) and expanded adult residential care homes (E-ARCH). (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Subcontracts submitted for this standard included all required provisions. UHC CP provided evidence of having conducted annual audits of its delegates and subcontractors reviewed under this standard. For those delegates, UHC CP provided evidence of ongoing monitoring, which included regular review of reports from subcontractors. UHC CP routinely conducted interrater reliability (IRR) reviews on health and functional assessments and level of care assessments completed by the CCMAs to ensure consistency, accuracy, and timeliness of the assessments. UHC CP also submitted meeting minutes of its Delegation Oversight Committee and joint operating committees (JOCs) with delegates.

UHC CP's policies and procedures addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with the MQD.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard III—Credentialing

Strengths

UHC CP demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing providers that effectively evaluated providers and complied with the National Committee for Quality Assurance (NCQA) credentialing standards and guidelines. A review of

10 credentialing files and 10 recredentialing files demonstrated that UHC CP implemented its annual credentialing plan and policies and procedures. UHC CP delegated the credentialing of BH providers to OptumHealth (Behavioral Health) and delegated credentialing of all other non-home- and community-based services (HCBS) providers to MDX Hawaii.

UHC CP provided evidence that its delegates conducted primary source verification of practitioners' credentials and conducted searches of federal exclusion databases to ensure that practitioners and providers were eligible for participation in federal healthcare programs. UHC CP also provided evidence of tracking and ensuring that providers completed and submitted ownership and disclosure documents at initial credentialing and recredentialing.

UHC CP provided evidence that it monitored MDX Hawaii and OptumHealth (Behavioral Health) by regularly reviewing reports, compiling quarterly scorecards, performing file audits, and conducting an annual assessment.

A file review of four organizational providers for initial assessment and five organizational providers for reassessment confirmed that UHC CP followed policies, procedures, and NCQA guidelines for the assessment of organizational providers. Specifically, for non-accredited providers, UHC CP's processes assured that an on-site quality assessment was performed or that, in lieu of a site visit, UHC CP substituted a Centers for Medicare & Medicaid Services (CMS) or State quality review that was determined to meet the health plan's quality assessment criteria.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard IV—Quality Assessment and Performance Improvement

Strengths

Along with UHC CP's local, Hawaii-based staff members responsible for the quality assessment and performance improvement (QAPI) program and activities, additional support, leadership, and consultation from its national headquarters (i.e., the UnitedHealthcare Health Plan Quality Management Committee [QMC] and the National Quality Oversight Committee [NQOC]) were provided. The QAPI program was supported by numerous policies and procedures that guided the care and service delivery system and created the framework to conduct monitoring and improvement activities.

As required by its MQD contract, UHC CP maintained a Hawaii-licensed registered nurse (Vice President of Quality Improvement), responsible for oversight of the implementation and evaluation of the quality improvement (QI) program and the health plan's Chief Medical Officer (CMO) was the designated Hawaii-licensed physician responsible for implementation of the QI program. Additionally, a BH medical director (a Hawaii-based behavioral healthcare practitioner), was accountable for providing leadership and advisement on the BH aspects of the QI program, related to clinical care and safety.

The health plan's comprehensive quality improvement program description included its QAPI program organizational structure, roles and responsibilities of individuals, as well as national and regional supports, governance, and committee structure at all levels (i.e., local/Hawaii, regional, and national). Subcommittees, including those responsible for delegation oversight, physician advisory input, UM, and clinical and service quality, provided input to the health plan's QI program. UHC CP also included, as part

of the overall scope of its QAPI program, a population health management (PHM) strategy. The PHM strategy stratified UHC CP's membership based on healthcare needs. The overarching goals outlined in the PHM strategy were to maintain health, manage emerging risk, manage multiple chronic or complex illnesses, and address member safety and outcomes across treatment settings through UHC CP's programs and service delivery. UHC CP's QAPI program activities encompassed quality of care, patient safety, and quality of service. The annual QAPI program work plan described improvement activities that included major objectives, identification of responsible individuals or groups, and time frames for completion. The work plan also functioned as the basis for the health plan's annual evaluation of its QAPI program.

The UHC CP UM program description, policies and procedures, and UM report examples demonstrated UHC CP's ongoing monitoring of its service utilization patterns and detection of over- and underutilization. The Healthcare and Quality Utilization Management Committee (HQUM)minutes and interview discussion with UHC CP staff members confirmed that the health plan used these findings in its overall QAPI program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

UHC CP had Hawaii-based information systems (IS) staff members and national corporate support for the management of all operations related to development and maintenance of its health information systems. Certain delegated functions were outside UHC CP's IS structure and required the delegates to collect and report data to UHC CP (i.e., MDX for credentialing and LogistiCare for transportation services). The delegates received oversight and periodic audits from the health plan to ensure data validity and completeness. The delegates were also required to maintain data security procedures and disaster recovery processes.

During the virtual site review, UHC CP provided presentations, data and process flow diagrams, and system demonstration of its management information system (MIS), which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. UHC CP also had processes in place to verify the accuracy and completeness of its claims and encounter data by examining and comparing monthly paid claims volume by product line, conducting claims audits, and running the data through various system edits within its claims systems. The health plan implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

UHC CP had data security measures and corporate-level (i.e., UnitedHealthcare Group [UHG]) policies and plans related to disaster planning and recovery and business continuity, as well as local-level procedures depicting Hawaii leadership roles and responsibilities in the event of a disaster. UHC CP had several policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed,

acquired, or disclosed as a result of a breach. During the virtual site review, UHC CP confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

The UHG national committee structure is primarily responsible for the development, review, and approval of clinical practice guideline (CPG) topics. Selection and review by three UHG national committees (i.e., Medical Technology Assessment Committee, National Medical Care Management Committee, and NQOC) ensures that only nationally recognized guidelines or consensus documents are adopted. To meet the healthcare needs of UHC CP members, UHC CP participated in the national process and determined the relevance of CPGs for its populations and conditions. UHC CP's CPG policies and procedures described practices for selecting CPGs that are based on valid, reliable clinical evidence or consensus of healthcare professionals; adopted in consultation with contracting healthcare professionals; and reviewed and updated periodically.

UHC CP's CPGs are disseminated to providers online via links to UHC CP's provider website and providers are also notified of CPGs through newsletters and other mailings. Dissemination of CPGs to members occurred through member services. Further, members were informed in the member handbook of their right to request CPG information.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

UHC CP had a compliance plan and several policies and procedures that guided the health plan's compliance program. UHC CP provided initial onboarding and annual training to staff members about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security.

UHC CP implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. Using various analytic tools, UHC CP conducted prospective and retrospective claim investigation processes to identify any concerning provider billing patterns. The analytic tools allowed UHC CP to filter providers by various demographics such as region or specialty type to assist in identifying trends within a certain area or type of network provider that may indicate potential FWA. UHC CP also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members.

If UHC CP became aware of or identified any potential FWA, the health plan notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the

State, UHC CP had a Provider Payment Suspension standard operating procedure (SOP) to suspend payments to providers upon notification from the State.

The health plan had processes in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that UHC CP became aware of a change in a network provider's circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, UHC CP notified the State using the Provider/Employee Integrity and Education Report. Utilizing provider contracts and the provider manual, UHC CP informed providers of their requirement to report overpayments to the health plan, return the overpayment within 60 days, and notify the health plan in writing of the reason for the overpayment.

Areas Requiring Improvement

The compliance plan, UHC CP Compliance & Ethics Program ("Compliance Plan"), provided by the health plan was dated June 2014. The Compliance Plan stated that UHC CP has a locally employed Compliance Officer who reports indirectly to the UHC CP Plan President and directly to a Regional Compliance Officer, who in turn reports up through a chain of command to the Chief Medicaid Compliance Officer. However, the UHC CP Internal Management Structure document showed a direct reporting line from Compliance to the Health Plan CEO. The FWA Prevention, Detection, Investigation and Reporting policy stated that the Compliance Officer reports to the Plan President as well as to the Regional Compliance Officer and indirectly to the national Chief Medicaid Compliance Officer. During the Program Integrity interview session, health plan staff members confirmed that the UHC CP Compliance Officer has a direct line to the health plan CEO. The health plan's Compliance Plan stated that the Compliance Oversight Committee met monthly; however, the Compliance Oversight Committee Charter stated that the committee met quarterly. The health plan's Compliance Plan did not describe the Board of Directors' involvement in the health plan's compliance program.

UHC CP must update its UHCCP Compliance & Ethics Program to be consistent with current reporting structures between the Compliance Officer, the health plan CEO, and the Board of Directors. In addition, the Compliance Plan must be updated to describe the Board of Directors' involvement in the health plan's compliance program. Finally, the Compliance Plan must be updated to reflect that the Compliance Oversight Committee meets quarterly and not monthly.

UHC CP had processes in place to report overpayments due to FWA to the State quarterly using the State's Fraud Waste and Abuse Summary Report template and annually using the State's Overpayment Report template. However, UHC CP did not have any policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

UHC CP must develop and implement a policy, procedure, and/or process to ensure that the health plan and subcontractors report to the State within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.

Standard VIII—Enrollment and Disenrollment

Strengths

UHC CP had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. The health plan demonstrated its processes for accepting the daily eligibility file from the State and loading the file into Community Strategic Platform (CSP) Facets where new member records would be created, and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the health plan data and the State eligibility file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, UHC CP customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. UHC CP did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

UHC CP had a non-discrimination policy and a notice to members to inform enrolled members that UHC CP does not discriminate against members or use any policy or practice that has the effect of discriminating against members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

'Ohana Health Plan QUEST Integration ('Ohana QI)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

'Ohana's participating provider agreement, QI provider manual, and network development policy confirmed that 'Ohana had a comprehensive process for the selection of its network providers. The provider manual demonstrated that 'Ohana communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to participate in treatment decisions. 'Ohana staff members confirmed during the virtual site review interview discussion that it did not object to providing any of its services based on moral or religious grounds. Further, the health plan had effective processes to address situations in which providers may express such objections and ensure members obtain an alternative provider as well as the timely provision of notification to members of the change in benefits coverage.

'Ohana demonstrated that effective processes were in place to notify an individual or group of providers when the health plan denied participation in its provider network. Additionally, 'Ohana's processes included timely notification to DHS if individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

'Ohana provided educational sessions in accordance with the health plan's provider education policy that informed providers about health plan operations, managed care, claims processing, utilization management (UM), and member rights and responsibilities. 'Ohana provided access to educational

materials to providers unable to attend either one-on-one or group education sessions through the health plan's secure web portal, sent by mail or through facilitator led web-based teleconference training.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard II—Subcontracts and Delegation

Strengths

'Ohana had subcontracts for delegation of network management and vision services to Premier Vision; network management and audiology services to Hear USA; non-emergency medical transportation to Intelliride; and pharmacy benefits management to CVS Caremark. 'Ohana also reported subcontracts with several community case management agencies (CCMAs) for service coordination to members receiving long-term services and supports (LTSS) in community care foster family homes (CCFFH) and expanded adult residential care homes (E-ARCH). The health plan subcontracted with several provider groups and clinics for credentialing of its providers. (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Template subcontract agreements and a sample of executed subcontracts submitted were reviewed to ensure all required provisions were included. 'Ohana provided evidence of having conducted annual audits of its delegates reviewed under this standard. For those delegates, 'Ohana provided evidence of ongoing monitoring, which included regular review of reports from delegates and the use of a vendor scorecard to monitor performance. Ohana utilized Compliance 360, a vendor management tool, to track performance, review scorecards and operational deliverables, track delegate audit dates, and conduct the formal audits.

'Ohana's QUEST Integration Program Attachment addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with the MQD.

Areas Requiring Improvement

One executed CCMA delegation agreement was selected for review to ensure all required contract provisions were present. The delegation agreement for Above and Beyond Case Management included all required contract provisions; however, the contract required retention of medical records for seven years, which was not in compliance with the State's health plan contract (10 years).

'Ohana must amend its current agreement with Above and Beyond Case Management or develop an additional contract or written agreement to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years). As only one CCMA agreement was reviewed for the purposes of the compliance review, HSAG recommends that 'Ohana review all currently executed CCMA contracts to ensure the medical record retention requirements are correct in all contracts.

Standard III—Credentialing

Strengths

‘Ohana demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing providers that effectively evaluated providers and complied with the National Committee for Quality Assurance (NCQA) credentialing standards and guidelines. A review of 10 credentialing files and 10 recredentialing files demonstrated that ‘Ohana implemented its credentialing policies and procedures and maintained comprehensive and well-organized credentialing files.

Through credentialing delegation agreements, pre-delegation audits, on-going monitoring and oversight, and annual audits, ‘Ohana demonstrated that it followed the health plan’s established policy and processes for delegation of managed care functions. ‘Ohana provided evidence that its delegates conducted primary source verification of practitioners’ credentials and conducted searches of federal exclusion databases to ensure that practitioners and providers were eligible for participation in federal healthcare programs. ‘Ohana also provided evidence that the health plan obtained completed ownership and disclosure documents at initial credentialing and recredentialing.

A file review of four organizational providers for initial assessment and five organizational providers for reassessment confirmed that ‘Ohana followed policies, procedures, and NCQA guidelines for the assessment of organizational providers. Specifically, for non-accredited providers, ‘Ohana’s processes assured that an on-site quality assessment was performed or that, in lieu of a site visit, ‘Ohana substituted a Centers for Medicare & Medicaid Services (CMS) or State quality review that was determined to meet the health plan’s quality assessment criteria.

The Hawaii Credentialing Committee minutes verified ‘Ohana’s process for medical director sign-off on clean files, peer review of files not meeting guidelines, and the medical director’s participation in the credentialing program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard IV—Quality Assessment and Performance Improvement

Strengths

Along with ‘Ohana’s local, Hawaii-based staff members responsible for the quality assessment and performance improvement (QAPI) program and activities, additional support, leadership, and consultation from its parent organization’s WellCare Corporate Quality Improvement Committee (QIC) and Corporate Sub-Committees were provided. ‘Ohana’s QAPI program was supported by numerous policies, procedures, and plans that guided the care and service delivery system and created the framework to conduct monitoring and improvement activities.

‘Ohana prepared an annual QAPI program description, QAPI work plan, and QAPI evaluation of the previous year’s quality program achievements. The QAPI program description included the health plan’s organizational and accountability structure, governance, corporate and local committee and sub-committee structure, goals, and quality improvement program objectives. The scope of the QAPI program activities applied to all member demographic groups, care settings, and types of services (both the quality of clinical care and non-clinical aspects of service). The annual QAPI work plan identified the

improvement activities, key objectives, topics, metrics, responsible party, responsible committee, goals, and quarterly reporting. The QAPI work plan served as the basis for ‘Ohana’s annual evaluation of its QAPI program. The annual evaluation demonstrated the use of data, trending, analysis, measurement against goals, identification of accomplishments and any barriers to achieving goals, and effectiveness of actions taken in the prior year. QIC meeting minutes described ‘Ohana’s routine review and reporting of data that monitored adherence to the QAPI work plan.

In addition, ‘Ohana provided its UM program description and applicable policies and procedures, which verified the health plan’s ongoing monitoring of its service utilization patterns and detection of over- and underutilization. Utilization Management Advisory Committee (UMAC) minutes and interview discussion during the virtual site review offered further evidence that ‘Ohana used UM tracking and data reports as part of its overall QAPI program.

‘Ohana’s robust QAPI program demonstrated that the health plan effectively evaluated access, timeliness, and quality of services provided to MedQUEST members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

‘Ohana provided presentations, data and process flow diagrams, and system demonstration of its information systems, which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. ‘Ohana also had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The health plan implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

‘Ohana had data security measures, policies, and plans related to disaster planning and recovery and business continuity. ‘Ohana had several policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed, acquired, or disclosed as a result of a breach. The health plan required all employees to complete privacy and security training at the time of hire and annually thereafter. During the virtual site review, ‘Ohana confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

‘Ohana’s process for the implementation and adoption of clinical practice guidelines (CPGs) was initiated through WellCare’s corporate policy and procedure that ensured CPGs are based on valid, reliable clinical evidence or consensus of healthcare professionals; developed in consultation with providers; consider the needs of enrolled members; and reviewed at least every two years and revised as necessary. Further, the CPGs supported quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. The process for selection, adoption, dissemination, and implementation of CPGs was also included in the QAPI program description.

‘Ohana had a variety of CPGs for medical conditions and for preventive care that included cardiovascular disease, asthma, epilepsy, and adolescent preventive health. The adoption of Preventive Health Guidelines were designed to detect and improve the health status of members by affording preventive care to screen for a variety of acute and potentially chronic illnesses. These guidelines also include interventions for prevention and early detection of disease, recommend the frequency and conditions for which interventions are required, and document the basis (scientific or recognized source) upon which the guidelines were based. In addition to the CPGs, the health plan provided the Clinical Practice Guideline Hierarchy, a supplemental resource tool for providers.

The Chief Medical Director of Medical Management or designee was responsible for submittal of CPGs to the Medical Policy Committee (MPC) for review, feedback, and approval. CPGs would then be distributed to either the Utilization Management Medical Advisory Committee or the QIC for approval and dissemination to providers. The health plan had processes for regular dissemination of CPG information to providers, including use of links to the website portal, provider manual, or through quarterly provider newsletters. Members were informed of how to access CPGs through information provided in the member handbook.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

‘Ohana had a compliance plan and several policies and procedures that guided the health plan’s compliance program. ‘Ohana provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. ‘Ohana’s Market Compliance Officer had a direct reporting line to the Plan President and was charged with identifying, tracking, mitigating, and reporting on operational compliance risks, chairing the Market Compliance Oversight Committee, and conducting day-to-day compliance activities.

‘Ohana utilized a case tracking system to track and report on compliance activities and FWA investigations. ‘Ohana implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. ‘Ohana’s Special Investigation Unit (SIU) utilized analytic tools such as Cotiviti and Star Sentinel, specifically designed for fraud detection and analysis in conjunction with other programs used for data mining, analysis, and reporting. The SIU performed claims analysis and peer comparison of provider claims billing patterns to identify outliers.

‘Ohana also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members.

If ‘Ohana became aware of or identified any potential FWA, the health plan notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the State, ‘Ohana had procedures to enable edits in Xcelys, its claims processing application, to suspend payments to providers upon notification from the State.

‘Ohana had processes in place to report overpayments due to FWA promptly using the State’s Suspected Fraud Waste and Abuse (SFA) reporting tool, quarterly using the State’s Fraud Waste and Abuse Summary Report (FAS) template, and annually using the State’s Overpayment Report template. ‘Ohana also had a policy and procedure in place to notify the State’s financial office in the event it received an overpayment of its capitation.

‘Ohana had a mechanism in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that ‘Ohana became aware of a change in a network provider’s circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, ‘Ohana notified the State using the Provider Suspension and Termination report. Utilizing the provider manual, ‘Ohana informed providers of their requirement to report overpayments to the health plan, return the overpayment within 60 days, and notify the health plan in writing of the reason for the overpayment.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VIII—Enrollment and Disenrollment

Strengths

‘Ohana had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. The health plan demonstrated its processes for accepting the daily eligibility file from the State and loading the file into its enrollment system, Xcelys, where new member records would be created, and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the health plan data and the State eligibility file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, ‘Ohana customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan . ‘Ohana did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member’s circumstance that might affect the member’s eligibility.

‘Ohana had a non-discrimination policy for enrollment and disenrollment of members that stated that ‘Ohana does not discriminate against members or use any policy or practice that has the effect of discriminating against members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

‘Ohana Community Care Services (‘Ohana CCS)

2020 Review of Compliance with Standards

Standard I—Provider Selection

Strengths

Community Care Services (CCS), ‘Ohana’s BHO, confirmed through its participating provider agreement, provider manual, and network development policy that CCS had a comprehensive process for the selection of its network providers. The provider manual demonstrated that CCS communicated and supported network providers to advise and advocate for members regarding members’ health status, medical care, treatment options, and the right to participate in treatment decisions. CCS staff members confirmed during the virtual site review interview discussion that it did not object to providing any of its services based on moral or religious grounds. Further, the BHO had effective processes to address situations in which providers may express such objections and ensure members obtain an alternative provider as well as the timely provision of notification to members of the change in benefits coverage.

CCS demonstrated that effective processes were in place to notify an individual or group of providers when the BHO denied participation in its provider network. Additionally, CCS’ processes included timely notification to DHS if individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

The CCS program provided educational sessions in accordance with the BHO’s provider education policy that informed providers about BHO operations, managed care, claims processing, utilization management (UM), and member rights and responsibilities. CCS provided access to educational materials to providers unable to attend either one-on-one or group education sessions through the BHO’s secure web portal. Additionally, educational materials may be sent by mail or through facilitator led web-based teleconference training.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard II—Subcontracts and Delegation

Strengths

CCS had subcontracts for delegation of non-emergency medical transportation to Intelliride and pharmacy benefits management to CVS Caremark. CCS also reported subcontracts with several community-based case management agencies (CBCM) for care coordination/case management to the seriously mentally ill (SMI) members enrolled in the BHO. (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Template subcontract agreements and a sample of executed subcontracts submitted were reviewed to ensure all required provisions were included. CCS provided evidence of having conducted annual audits

of its delegates reviewed under this standard. For those delegates, CCS provided evidence of ongoing monitoring, which included regular review of reports from delegates and the use of a vendor scorecard to monitor performance. CCS utilized Compliance 360, a vendor management tool, to track performance, review scorecards and operational deliverables, track delegate audit dates, and conduct the formal audits.

The Hawaii CCS Program Attachment addressed the requirements for submitting subcontracts to the MQD for review and approval prior to subcontracting and for providing notice to the MQD if terminations of subcontractors are anticipated to materially affect the BHO's ability to fulfill the terms of its contract with MQD.

Areas Requiring Improvement

The Intelliride contract, CVS Caremark contract, and one executed CBCM (Care Hawaii Inc.) delegation contract was selected for review to ensure all required contract provisions were present. The delegation agreement for Care Hawaii Inc. included all required contract provisions. The Intelliride and CVS Caremark contracts also included all required contract provisions; however, the contracts required retention of medical records for seven years, which was not in compliance with the State's health plan contract (10 years).

CCS must amend its current agreements with Intelliride and CVS Caremark or develop an additional contract or written agreement to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

Standard III—Credentialing

Strengths

CCS demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing independent licensed practitioners that effectively evaluated practitioners and complied with the National Committee for Quality Assurance (NCQA) credentialing standards and guidelines. A desk review of 10 credentialing and 10 recredentialing provider files revealed timely primary source verification of credentials, timely recredentialing, and timely exclusion searches using the NCQA-approved databases. CCS also provided evidence of monthly searches to ensure practitioners and providers had not been excluded from federal healthcare participation between recredentialing cycles. Further, the BHO's credentialing and recredentialing files reviewed during the desk review verified that staff members had obtained completed ownership and disclosure documents at the time of credentialing and recredentialing as required. Practitioner credentialing and recredentialing applications contained all required information and confirmed that CCS maintained comprehensive and well-organized credentialing and recredentialing files.

Although CCS did not currently delegate credentialing functions, the BHO maintained a credentialing delegation policy and processes for pre-delegation audits, ongoing monitoring and oversight, as well as annual audits (formal review) of delegates.

A file review of five organizational providers for initial assessment and five organizational providers for reassessment confirmed that the BHO followed policies, procedures, and NCQA guidelines for the assessment of organizational providers. Specifically, for non-accredited providers, the BHO's processes

assured that an on-site quality assessment was performed by CCS or that, in lieu of a site visit, CCS substituted a State quality review or other entity site review that was determined to meet the BHO's quality assessment criteria.

The Hawaii Credentialing Committee minutes verified CCS' process for medical director sign-off on clean files, peer review of files not meeting guidelines, process that ensured nondiscriminatory credentialing and recredentialing, and the medical director's participation in the credentialing program.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard IV—Quality Assessment and Performance Improvement

Strengths

Along with CCS' local, Hawaii-based staff members responsible for the quality improvement program and activities, additional support, leadership, and consultation from its parent organization's WellCare Corporate Quality Improvement Committee (QIC) and Corporate Sub-Committees were provided. The CCS quality improvement program was supported by numerous policies, procedures, and plans that guided the care and service delivery system and created the framework to conduct monitoring and improvement activities.

CCS prepared an annual quality improvement program description and quality improvement evaluation of the previous year's quality program achievements. The quality improvement program description included the BHO's organizational and accountability structure, governance, corporate and local committee and sub-committee structure, key performance indicators, and CCS program strategy and objectives. The scope of the quality improvement program activities applied to specialized behavioral health services for eligible members determined to have an SMI or serious and persistent mental illness (SPMI) diagnosis. The quality improvement program description served as the basis for CCS' annual evaluation of its quality improvement program. The annual evaluation demonstrated that CCS evaluated the overall effectiveness of its quality improvement program through the use of data, analysis, measurement against goals, identification of accomplishments and any barriers to achieving goals, and recommendations for the coming year. QIC meeting minutes described CCS' routine review and reporting of data that monitored adherence to the quality improvement program objectives.

In addition, CCS provided its UM program description, annual UM evaluation, pharmacy evaluation, and applicable policies and procedures, which verified the BHO's ongoing monitoring of its service utilization patterns and detection of over- and underutilization. Utilization Management Advisory Committee (UMAC) minutes and interview discussion during the virtual site review offered further evidence that CCS used UM tracking and data reports as part of its overall quality improvement program.

Consistent with its State contract, CCS assigned its medical director as the designated physician responsible for implementation of the quality improvement program and leadership of QIC. CCS also had a behavioral health medical director (a Hawaii-based behavioral health physician) responsible for advisement of the CCS program, including behavioral health elements of the quality improvement program. CCS' comprehensive quality improvement program demonstrated that the BHO effectively evaluated access, timeliness, and quality of services provided to CCS members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard V—Health Information Systems

Strengths

CCS provided presentations, data and process flow diagrams, and system demonstration of its information systems, which provided evidence of its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. CCS also had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The BHO implemented an encounter data collection and submission process to ensure that accurate and complete data were submitted to the State using the standardized 837 and National Council for Prescription Drug Programs (NCPDP) formats.

CCS had data security measures, policies, and plans related to disaster planning and recovery and business continuity. CCS had several policies, procedures, and processes to promptly report to the State any breach of unsecured protected health information (PHI) and notify each individual whose unsecured PHI was accessed, acquired, or disclosed as a result of a breach. The BHO required all employees to complete privacy and security training at the time of hire and annually thereafter. During the virtual site review, CCS confirmed that it did not have any PHI breaches affecting more than 500 members in the preceding 12 months.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VI—Practice Guidelines

Strengths

CCS' process for the implementation and adoption of clinical practice guidelines (CPGs) was initiated through WellCare's corporate policy and procedure that ensured CPGs are based on valid, reliable clinical evidence or consensus of healthcare professionals; developed in consultation with providers; consider the needs of enrolled members; and reviewed at least every two years and revised as necessary. Further, the CPGs supported quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. The process for selection, adoption, dissemination, and implementation of CPGs was also included in the QI program description.

CCS had numerous CPGs for behavioral health disorders, including anxiety disorders, depressive disorders in children and adolescents, schizophrenia, substance abuse disorders, and suicidal behavior. Links to the CPGs were available to providers on the BHO's website through the provider portal, and information regarding the online CPGs and other provider resources were published in provider newsletters or the provider manual. The BHO clinical practice guideline policy and procedure identified that CPGs would be available for review and dissemination upon a member's request.

To ensure that actual practice was consistent with the CPGs, CCS staff members confirmed that interrater reliability studies were conducted at least annually to ensure that the desired practice was consistent with the applicable guideline.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VII—Program Integrity

Strengths

The BHO's compliance plan was a WellCare corporate document, was comprehensive, and addressed each of the required provisions. The compliance plan and several policies and procedures guided the BHO's compliance program. CCS provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. CCS had a compliance officer who collaborated with and reported to the Ohana Health Plan compliance officer but also had a direct line to the Plan President and was charged with identifying, tracking, mitigating, and reporting on operational compliance risks, participating in the Market Compliance Oversight Committee, and conducting day-to-day compliance activities.

CCS utilized a case tracking system to track and report on compliance activities and FWA investigations. CCS implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. CCS' Special Investigation Unit (SIU) utilized analytic tools such as Cotiviti and Star Sentinel, specifically designed for fraud detection and analysis in conjunction with other programs used for data mining, analysis, and reporting. The SIU performed claims analysis and peer comparison of provider claims billing patterns to identify outliers. CCS also conducted Verification of Services (VOS) procedures to verify that services billed by providers were actually provided to its members.

If CCS became aware of or identified any potential FWA, the BHO notified the State Medicaid Fraud Control Unit within the required time frame. If an FWA case was determined to be credible by the State, CCS had procedures to enable edits in Xcelys, its claims processing application, to suspend payments to providers upon notification from the State.

CCS had processes in place to report overpayments due to FWA promptly using the State's Suspected Fraud Waste and Abuse (SFA) reporting tool, quarterly using the State's Fraud Waste and Abuse Summary Report (FAS) template, and annually using the State's Overpayment Report template. CCS also had a policy and procedure in place to notify the State's financial office in the event it received an overpayment of its capitation.

CCS had a mechanism in place to verify that all network providers were enrolled with the State as Medicaid providers. In the event that CCS became aware of a change in a network provider's circumstances that affected his or her ability to participate in the managed care program, or if a provider was terminated from the network, CCS notified the State using the Provider Suspension and Termination report. Utilizing the CCS provider manual, the BHO informed providers of their requirement

to report overpayments to the plan, return the overpayment within 60 days, and notify the plan in writing of the reason for the overpayment.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Standard VIII—Enrollment and Disenrollment

Strengths

CCS had systems, processes, and workflows to accept all individuals enrolled into the BHO without restrictions. The BHO demonstrated its processes for accepting the daily eligibility file from the State and loading the file into its enrollment system, Xcelys, where new member records would be created, and existing member records would be updated with any demographic and eligibility changes. Any discrepancies between the BHO data and the State enrollment file were investigated and remediated.

As all member enrollment and disenrollment decisions were made by the State, CCS customer service staff members referred BHO members to the State eligibility worker in the event the member wanted to request disenrollment from the BHO. CCS did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it became aware of a change in a member's circumstance that might affect the member's eligibility.

CCS had a non-discrimination policy for enrollment and disenrollment of members that stated that CCS does not discriminate against members or use any policy or practice that has the effect of discriminating against members.

Areas Requiring Improvement

There were no required corrective actions for this standard.

Hawaii MY 2019 Performance Measure Rates

- Adult Core Set Reporting -

Measure	Measure Description	Methodology[1]	2020 Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	2,558	2,558	1,738	67.94%
Adult BMI Assessment	18–64 Years	Mixed	85,923	—	—	86.62%
Adult BMI Assessment	65–74 Years	Mixed	9,420	—	—	94.94%
Adult BMI Assessment	Total	Mixed	95,343	—	—	87.35%
Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	3,259	3,259	1,682	51.61%
Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	309	309	194	62.78%
Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	3,568	3,568	1,876	52.58%
Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	3,259	3,259	1,183	36.30%
Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	309	309	146	47.25%
Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	3,568	3,568	1,329	37.25%
Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	2,359,271	2,359,271	61	2.59
Asthma Medication Ratio	19–50 Years	Admin	1,357	1,357	552	40.68%
Asthma Medication Ratio	51–64 Years	Admin	738	738	368	49.86%
Asthma Medication Ratio	Total	Admin	2,095	2,095	920	43.91%
Breast Cancer Screening	50–64 Years	Admin	13,394	13,394	7,880	58.83%
Breast Cancer Screening	65–74 Years	Admin	4,882	4,882	2,770	56.74%
Breast Cancer Screening	Total	Admin	18,276	18,276	10,650	58.27%
Cervical Cancer Screening	Cervical Cancer Screening	Mixed	62,191	—	—	62.80%
Chlamydia Screening in Women	21–24 Years	Admin	4,370	4,370	2,433	55.68%
Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Mixed	14,084	—	—	39.74%
Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Mixed	3,472	—	—	22.61%
Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Mixed	17,556	—	—	36.02%
Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Mixed	14,084	—	—	86.87%
Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Mixed	3,472	—	—	91.58%
Comprehensive Diabetes Care	HbA1c Testing Total	Mixed	17,556	—	—	87.90%
Controlling High Blood Pressure	18–64 Years	Hybrid	21,305	—	—	59.21%
Controlling High Blood Pressure	65–85 Years	Hybrid	7,992	—	—	68.75%
Controlling High Blood Pressure	Total	Hybrid	29,297	—	—	61.78%
COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	882,286	882,286	341	38.65
COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	270,725	270,725	236	87.17
COPD or Asthma in Older Adults Admission Rate	Total	Admin	1,153,011	1,153,011	577	50.04
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	3,115	3,115	2,274	73.00%
Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	1,989,132	1,989,132	328	16.49
Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	269,725	269,725	23	8.53
Diabetes Short-Term Complications Admission Rate	Total	Admin	2,258,857	2,258,857	351	15.54

Hawaii MY 2019 Performance Measure Rates

- Adult Core Set Reporting -

Measure	Measure Description	Methodology[1]	Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]
Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	2,224	2,224	500	22.48%
Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	63	63	9	14.29%
Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	2,224	2,224	449	20.19%
Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	63	63	7	11.11%
Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	1,539	1,539	658	42.76%
Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	51	51	18	35.29%
Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	1,539	1,539	401	26.06%
Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	51	51	12	23.53%
Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	1,271	1,271	646	50.83%
Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	46	46	18	39.13%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	1,271	1,271	400	31.47%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	46	46	12	26.09%
Heart Failure Admission Rate	18-64 Years	Admin	1,989,132	1,989,132	984	49.47
Heart Failure Admission Rate	65+ Years	Admin	270,725	270,725	381	140.73
Heart Failure Admission Rate	Total	Admin	2,259,857	2,259,857	1,365	60.40
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	2,782	2,782	1,044	37.53%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	305	305	99	32.46%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	975	975	364	37.33%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	153	153	38	24.84%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	5,536	5,536	2,309	41.71%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	209	209	76	36.36%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	8,584	8,584	3,370	39.26%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	638	638	199	31.19%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	2,782	2,782	362	13.01%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	305	305	12	3.93%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	975	975	153	15.69%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	153	153	6	3.92%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	5,536	5,536	801	14.47%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	209	209	13	6.22%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	8,584	8,584	1,181	13.76%
Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	638	638	30	4.70%

Hawaii MY 2019 Performance Measure Rates

- Adult Core Set Reporting -

Measure	Measure Description	Methodology[1]	Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]
Screening for Depression and Follow-Up Plan	18–64 Years	Admin	108,222	108,217	19,169	17.71%
Screening for Depression and Follow-Up Plan	65+ Years	Admin	17,556	17,551	3,969	22.61%
Plan All-Cause Readmissions	Observed Readmission Rate—Ages 18–44*	Admin	3,209	3,209	275	8.57%
Plan All-Cause Readmissions	Observed Readmission Rate—Ages 45–54*	Admin	1,898	1,898	184	9.69%
Plan All-Cause Readmissions	Observed Readmission Rate—Ages 55–64*	Admin	2,682	2,682	283	10.55%
Plan All-Cause Readmissions	Observed Readmission Rate—Total*	Admin	7,789	7,789	742	9.53%
Plan All-Cause Readmissions	Expected Readmission Rate—Ages 18–44*	Admin	3,209	3,209	279	8.69%
Plan All-Cause Readmissions	Expected Readmission Rate—Ages 45–54*	Admin	1,898	1,898	201	10.58%
Plan All-Cause Readmissions	Expected Readmission Rate—Ages 55–64*	Admin	2,682	2,682	321	11.97%
Plan All-Cause Readmissions	Expected Readmission Rate—Total*	Admin	7,789	7,789	801	10.28%
Plan All-Cause Readmissions	Observed/Expected Ratio—Ages 18–44*	Admin	3,209	279	275	0.99
Plan All-Cause Readmissions	Observed/Expected Ratio—Ages 45–54*	Admin	1,898	201	184	0.92
Plan All-Cause Readmissions	Observed/Expected Ratio—Ages 55–64*	Admin	2,682	321	283	0.88
Plan All-Cause Readmissions	Observed/Expected Ratio—Total*	Admin	7,789	801	742	0.93
Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	116,058	116,058	112	0.97
Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	29,625	29,625	82	2.77
Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	31,051	31,051	109	3.51
Plan All-Cause Readmissions	Outliers—Total*	Admin	176,734	176,734	303	1.71
Prenatal and Postpartum Care	Postpartum Care	Hybrid	5,645	—	—	65.74%
Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	5,968	5,968	697	11.68%
Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	1,153	1,153	109	9.45%

* For this indicator, a lower rate indicates better performance.

Hawaii MY 2019 Performance Measure Rates

- Adult Core Set Reporting -

Measure	Measure Description	Methodology[1]	Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]

This spreadsheet contains the results for the federal fiscal year 2020 core set of adults' health care quality measures. HSAG derived the weighted rates based on the HEDIS 2020 data (calendar year 2019) and a document titled "Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting (updated February 2020)." Please consider the following footnotes when reviewing this spreadsheet:

1. The Methodology column identifies the data collection methodology reported by the QI health plans (i.e., AlohaCare, HMSA, Kaiser, 'Ohana, and UHC). Admin measures indicate that all QI health plans reported individual rates using administrative data only. Hybrid measures indicate that all QI health plans reported individual rates using both administrative and medical record data. If different methods were used (i.e., some plans reported admin and others reported hybrid), then the methodology is listed as Mixed on the spreadsheet.
2. The Eligible Population column presents the sum of the eligible populations reported by the five QI health plans. The total eligible population for these measures is derived using administrative data from submitted claims and encounters regardless of the data collection methodology (i.e., admin, hybrid, or mixed).
3. The Denominator column presents the denominator for measures depending on the methodology used to calculate the measure. If a measure was calculated using a hybrid or mixed methodology, then the denominator is presented as "—".
4. The Numerator column presents the sum of the numerators reported by the five QI health plans when reported using the admin method. For measures calculated using the hybrid or mixed methods, the numerator is presented as "—".
5. The Weighted Average presents the statewide weighted average of the rates reported by the five QI health plans. The statewide weighted average is calculated by aggregating adjusted rates across all health plans, weighted by their eligible population size.

HI MY 2019 Performance Measure Rates
- Child Core Set Reporting -

Measure	Measure Description	Methodology[1]	2020			
			Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]
Adolescent Well-Care Visits	Adolescent Well-Care Visits	Mixed	54,938	—	—	54.98%
Ambulatory Care—Total	Emergency Department Visits—<1 Year*	Admin	96,311	96,311	8,383	87.04
Ambulatory Care—Total	Emergency Department Visits—1–9 Years*	Admin	839,376	839,376	34,953	41.64
Ambulatory Care—Total	Emergency Department Visits—10–19 Years*	Admin	815,730	815,730	21,799	26.72
Ambulatory Care—Total	Emergency Department Visits—Total*,[6]	Admin	1,751,417	1,751,417	65,135	37.19
Asthma Medication Ratio	5–11 Years	Admin	667	667	455	68.22%
Asthma Medication Ratio	12–18 Years	Admin	562	562	327	58.19%
Asthma Medication Ratio	Total–Ages 5 to 18 Years	Admin	1,229	1,229	782	63.63%
Childhood Immunization Status	DTaP	Mixed	5,789	—	—	73.33%
Childhood Immunization Status	IPV	Mixed	5,789	—	—	83.12%
Childhood Immunization Status	MMR	Mixed	5,789	—	—	86.72%
Childhood Immunization Status	HiB	Mixed	5,789	—	—	85.22%
Childhood Immunization Status	Hepatitis B	Mixed	5,789	—	—	81.52%
Childhood Immunization Status	VZV	Mixed	5,789	—	—	85.42%
Childhood Immunization Status	Pneumococcal Conjugate	Mixed	5,789	—	—	73.64%
Childhood Immunization Status	Combination 3	Mixed	5,789	—	—	66.55%
Chlamydia Screening in Women	16–20 Years	Admin	5,024	5,024	2,437	48.51%
Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	256	256	152	59.38%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	256	256	99	38.67%
Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	526	526	245	46.58%
Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	80	80	46	57.50%
Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Mixed	6,487	—	—	66.17%
Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Mixed	6,487	—	—	30.86%
Immunizations for Adolescents	HPV	Mixed	6,487	—	—	34.15%
Immunizations for Adolescents	Meningococcal	Mixed	6,487	—	—	68.37%
Immunizations for Adolescents	Tdap	Mixed	6,487	—	—	72.94%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	5,645	—	—	83.20%
Screening for Depression and Follow-Up Plan	12–17 Years	Admin	32,780	32,469	10,144	31.24%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	73,053	—	—	84.29%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	42,894	—	—	85.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	115,947	—	—	84.69%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	73,053	—	—	80.17%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	42,894	—	—	79.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	115,947	—	—	79.87%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	73,053	—	—	79.79%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	42,894	—	—	79.35%

HI MY 2019 Performance Measure Rates

- Child Core Set Reporting -

Measure	Measure Description	Methodology[1]	Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	115,947	—	—	79.62%
Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Mixed	5,487	—	—	1.95%
Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Mixed	5,487	—	—	0.95%
Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Mixed	5,487	—	—	1.72%
Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Mixed	5,487	—	—	3.50%
Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Mixed	5,487	—	—	6.99%
Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Mixed	5,487	—	—	11.75%
Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Mixed	5,487	—	—	73.15%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Mixed	27,974	—	—	73.80%

* For this indicator, a lower rate indicates better performance.

Measure	Measure Description	Methodology[1]	Eligible Population[2]	Denominator[3]	Numerator[4]	Weighted Average[5]

This spreadsheet pertains to the data submission for the federal fiscal year 2020 core set of children's health care quality measures. HSAG derived the weighted rates based on the HEDIS 2020 data (calendar year 2019) and a document titled "Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting (updated February 2020)." Please consider the following footnotes when reviewing this spreadsheet:

1. The Methodology column identifies the data collection methodology reported by the QI health plans (i.e., AlohaCare, HMSA, Kaiser, 'Ohana, and UHC). Admin measures indicate that all QI health plans reported individual rates using administrative data only. Hybrid measures indicate that all QI health plans reported individual rates using both administrative and medical record data. If different methods were used (i.e., some plans reported admin and others reported hybrid), then the methodology is listed as Mixed on the spreadsheet.
2. The Eligible Population column presents the sum of the eligible populations reported by the five QI health plans. The total eligible population for these measures is derived using administrative data from submitted claims and encounters regardless of the data collection methodology (i.e., admin, hybrid, or mixed).
3. The Denominator column presents the denominator for measures depending on the methodology used to calculate the measure. If a measure was calculated using a hybrid or mixed methodology, then the denominator is presented as "—".
4. The Numerator column presents the sum of the numerators reported by the five QI health plans when reported using the admin method. For measures calculated using the hybrid or mixed methods, the numerator is presented as "—".
5. The Weighted Average presents the statewide weighted average of the rates reported by the five QI health plans. The statewide weighted average is calculated by aggregating adjusted rates across all health plans, weighted by their eligible population size.
6. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* rate was calculated by HSAG to only include the following age indicators: <1 Year, 1–9 Years, and 10–19 Years.

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	14,742	9,044	14,742	61.35%
QI	AlohaCare	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	8,563	6,328	8,563	73.90%
QI	AlohaCare	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	2,798	2,239	2,798	80.02%
QI	AlohaCare	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	26,103	17,611	26,103	67.47%
QI	HSMA	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	40,795	29,053	40,795	71.22%
QI	HSMA	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	23,264	19,019	23,264	81.75%
QI	HSMA	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	4,097	3,522	4,097	85.97%
QI	HSMA	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	68,156	51,594	68,156	75.70%
QI	KFHP	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	6,190	4,955	6,190	80.05%
QI	KFHP	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	3,807	3,434	3,807	90.20%
QI	KFHP	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	910	872	910	95.82%
QI	KFHP	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	10,907	9,261	10,907	84.91%
QI	'Ohana	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	6,865	4,157	6,865	60.55%
QI	'Ohana	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	6,608	5,267	6,608	79.71%
QI	'Ohana	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	3,407	2,999	3,407	88.02%
QI	'Ohana	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	16,880	12,423	16,880	73.60%
QI	UHCCP	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	9,815	5,698	9,815	58.05%
QI	UHCCP	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	8,672	6,827	8,672	78.72%
QI	UHCCP	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	9,797	9,210	9,797	94.01%
QI	UHCCP	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	28,284	21,735	28,284	76.85%
QI	Statewide	AAP	Adults' Access to Preventive/Ambulatory Health Services	20–44 Years	Admin	78,407	52,907	78,407	67.48%
QI	Statewide	AAP	Adults' Access to Preventive/Ambulatory Health Services	45–64 Years	Admin	50,914	40,875	50,914	80.28%
QI	Statewide	AAP	Adults' Access to Preventive/Ambulatory Health Services	65+ Years	Admin	21,009	18,842	21,009	89.69%
QI	Statewide	AAP	Adults' Access to Preventive/Ambulatory Health Services	Total	Admin	150,330	112,624	150,330	74.92%
QI	AlohaCare	ABA	Adult BMI Assessment	18–64 Years	Hybrid	13,914	353	391	90.28%
QI	AlohaCare	ABA	Adult BMI Assessment	65–74 Years	Hybrid	1,208	21	21	NA
QI	AlohaCare	ABA	Adult BMI Assessment	Total	Hybrid	15,122	374	412	90.78%
QI	HSMA	ABA	Adult BMI Assessment	18–64 Years	Hybrid	45,916	196	240	81.67%
QI	HSMA	ABA	Adult BMI Assessment	65–74 Years	Hybrid	2,455	9	10	NA
QI	HSMA	ABA	Adult BMI Assessment	Total	Hybrid	48,371	205	250	82.00%
QI	KFHP	ABA	Adult BMI Assessment	18–64 Years	Admin	7,536	7,150	7,536	94.88%
QI	KFHP	ABA	Adult BMI Assessment	65–74 Years	Admin	545	539	545	98.90%
QI	KFHP	ABA	Adult BMI Assessment	Total	Admin	8,081	7,689	8,081	95.15%
QI	'Ohana	ABA	Adult BMI Assessment	18–64 Years	Hybrid	8,082	125	136	91.91%
QI	'Ohana	ABA	Adult BMI Assessment	65–74 Years	Hybrid	1,286	21	23	NA
QI	'Ohana	ABA	Adult BMI Assessment	Total	Hybrid	9,368	146	159	91.82%
QI	UHCCP	ABA	Adult BMI Assessment	18–64 Years	Hybrid	10,475	287	307	93.49%
QI	UHCCP	ABA	Adult BMI Assessment	65–74 Years	Hybrid	3,926	101	104	97.12%
QI	UHCCP	ABA	Adult BMI Assessment	Total	Hybrid	14,401	388	411	94.40%
QI	Statewide	ABA	Adult BMI Assessment	18–64 Years	Mixed	85,923	—	—	86.62%
QI	Statewide	ABA	Adult BMI Assessment	65–74 Years	Mixed	9,420	—	—	94.94%
QI	Statewide	ABA	Adult BMI Assessment	Total	Mixed	95,343	—	—	87.35%
QI	AlohaCare	ACP	Advance Care Plan	LTSS Population	Admin	158	47	158	29.75%
QI	AlohaCare	ACP	Advance Care Plan	65+ Years	Admin	2,838	273	2,838	9.62%
QI	HSMA	ACP	Advance Care Plan	LTSS Population	Admin	3,918	11	3,918	0.28%
QI	HSMA	ACP	Advance Care Plan	65+ Years	Admin	3,918	11	3,918	0.28%
QI	KFHP	ACP	Advance Care Plan	LTSS Population	Admin	52	47	52	90.38%
QI	KFHP	ACP	Advance Care Plan	65+ Years	Admin	989	548	989	55.41%
QI	'Ohana	ACP	Advance Care Plan	LTSS Population	Hybrid	2,027	141	141	100.00%
QI	'Ohana	ACP	Advance Care Plan	65+ Years	Hybrid	4,012	339	341	99.41%
QI	UHCCP	ACP	Advance Care Plan	LTSS Population	Admin	1,747	154	1,747	8.82%
QI	UHCCP	ACP	Advance Care Plan	65+ Years	Admin	9,463	831	9,463	8.78%
QI	Statewide	ACP	Advance Care Plan	LTSS Population	Mixed	7,902	—	—	28.93%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	ACP	Advance Care Plan	65+ Years	Mixed	21,220	—	—	26.63%
QI	AlohaCare	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	82	18	82	21.95%
QI	AlohaCare	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	14	4	14	NA
QI	HSMA	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	316	146	316	46.20%
QI	HSMA	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	42	24	42	57.14%
QI	KFHP	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	97	64	97	65.98%
QI	KFHP	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	21	16	21	NA
QI	'Ohana	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	14	8	14	NA
QI	'Ohana	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	2	1	2	NA
QI	UHCCP	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	17	9	17	NA
QI	UHCCP	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	1	1	1	NA
QI	Statewide	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase	Admin	526	245	526	46.58%
QI	Statewide	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance Phase	Admin	80	46	80	57.50%
QI	AlohaCare	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	28,718	180	28,718	626.78
QI	AlohaCare	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	8,313	50	8,313	601.47
QI	AlohaCare	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	37,031	230	37,031	621.10
QI	HSMA	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	956,104	6	956,104	0.63
QI	HSMA	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	50,465	2	50,465	3.96
QI	HSMA	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	1,006,569	8	1,006,569	0.79
QI	KFHP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	298	1	298	335.57
QI	KFHP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	204	0	204	0.00
QI	KFHP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	502	1	502	199.20
QI	'Ohana	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	59,328	471	59,328	793.89
QI	'Ohana	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	31,368	97	31,368	309.23
QI	'Ohana	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	90,696	568	90,696	626.27
QI	UHCCP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	8,339	720	8,339	8634.13
QI	UHCCP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	23,876	1,135	23,876	4753.73
QI	UHCCP	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	32,215	1,855	32,215	5758.19
QI	Statewide	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	18–64 Years	Admin	1,052,787	1,378	1,052,787	130.89
QI	Statewide	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	65+ Years	Admin	114,226	1,284	114,226	1124.09
QI	Statewide	ALL CAUSE	All-Cause Unplanned Admission Rates for Patients With Multiple Chronic Conditions	Total	Admin	1,167,013	2,662	1,167,013	228.10
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	18,676	1,880	18,676	100.66
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	173,752	8,075	173,752	46.47
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	178,276	5,152	178,276	28.90
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	224,664	13,722	224,664	61.08

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	122,968	8,109	122,968	65.94
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	24,608	1,148	24,608	46.65
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	9,731	402	9,731	41.31
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	4,362	157	4,362	35.99
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	370,704	15,107	370,704	40.75
QI	AlohaCare	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	757,037	38,645	757,037	51.05
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	18,676	14,463	18,676	774.42
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	173,752	42,108	173,752	242.35
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	178,276	33,191	178,276	186.18
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	224,664	58,510	224,664	260.43
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	122,968	59,342	122,968	482.58
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	24,608	13,659	24,608	555.06
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	9,731	5,139	9,731	528.11
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	4,362	1,863	4,362	427.10
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	370,704	89,762	370,704	242.14
QI	AlohaCare	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	757,037	228,275	757,037	301.54
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	49,134	4,075	49,134	82.94
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	465,319	18,842	465,319	40.49
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	457,226	12,203	457,226	26.69
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	569,323	27,494	569,323	48.29
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	312,496	15,357	312,496	49.14
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	37,477	1,534	37,477	40.93
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	8,221	258	8,221	31.38
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	4,142	204	4,142	49.25
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	971,679	35,120	971,679	36.14
QI	HSMA	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	1,903,338	79,967	1,903,338	42.01
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	49,134	40,080	49,134	815.73
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	465,319	130,660	465,319	280.80
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	457,226	100,094	457,226	218.92
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	569,323	161,431	569,323	283.55
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	312,496	160,363	312,496	513.17
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	37,477	19,728	37,477	526.40
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	8,221	3,371	8,221	410.05
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	4,142	2,407	4,142	581.12
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	971,679	270,834	971,679	278.73
QI	HSMA	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	1,903,338	618,134	1,903,338	324.76
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	10,078	668	10,078	66.28
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	89,412	2,933	89,412	32.80
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	86,977	1,921	86,977	22.09
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	85,476	3,683	85,476	43.09
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	50,650	2,054	50,650	40.55
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	7,288	276	7,288	37.87
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	2,023	97	2,023	47.95
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	1,348	70	1,348	51.93
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	186,467	5,522	186,467	29.61
QI	KFHP	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	333,252	11,702	333,252	35.11
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	10,078	11,602	10,078	1151.22
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	89,412	36,256	89,412	405.49

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	86,977	27,230	86,977	313.07
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	85,476	54,454	85,476	637.07
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	50,650	52,625	50,650	1038.99
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	7,288	10,538	7,288	1445.94
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	2,023	2,979	2,023	1472.57
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	1,348	2,327	1,348	1726.26
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	186,467	75,088	186,467	402.69
QI	KFHP	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	333,252	198,011	333,252	594.18
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	7,589	764	7,589	100.67
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	47,093	2,279	47,093	48.39
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	38,844	1,121	38,844	28.86
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	109,765	7,317	109,765	66.66
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	92,614	7,187	92,614	77.60
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	23,470	1,525	23,470	64.98
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	14,751	782	14,751	53.01
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	7,456	335	7,456	44.93
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	93,526	4,164	93,526	44.52
QI	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	341,582	21,310	341,582	62.39
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	7,589	5,142	7,589	677.56
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	47,093	10,767	47,093	228.63
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	38,844	7,464	38,844	192.15
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	109,765	29,061	109,765	264.76
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	92,614	53,982	92,614	582.87
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	23,470	16,422	23,470	699.70
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	14,751	8,829	14,751	598.54
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	7,456	3,431	7,456	460.17
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	93,526	23,373	93,526	249.91
QI	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	341,582	135,098	341,582	395.51
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	106	22	106	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	15,196	1,459	15,196	96.01
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	28,982	2,410	28,982	83.16
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	6,230	545	6,230	87.48
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	1,015	50	1,015	49.26
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	79	0	79	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	51,608	4,486	51,608	86.92
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	106	22	106	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	15,196	4,335	15,196	285.27
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	28,982	13,579	28,982	468.53
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	6,230	3,182	6,230	510.75
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	1,015	415	1,015	408.87
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	79	29	79	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
CCS	'Ohana	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	51,608	21,562	51,608	417.80
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	10,834	996	10,834	91.93
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	63,800	2,824	63,800	44.26

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	54,407	1,402	54,407	25.77
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	162,093	9,708	162,093	59.89
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	125,611	9,382	125,611	74.69
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	60,372	3,013	60,372	49.91
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	41,922	1,937	41,922	46.20
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	18,985	954	18,985	50.25
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	129,041	5,222	129,041	40.47
QI	UHCCP	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	538,024	30,216	538,024	56.16
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	10,834	6,976	10,834	643.90
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	63,800	13,043	63,800	204.44
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	54,407	8,452	54,407	155.35
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	162,093	38,581	162,093	238.02
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	125,611	71,663	125,611	570.52
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	60,372	53,002	60,372	877.92
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	41,922	37,748	41,922	900.43
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	18,985	16,098	18,985	847.93
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	129,041	28,471	129,041	220.64
QI	UHCCP	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	538,024	245,563	538,024	456.42
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—<1 Year*	Admin	96,311	8,383	96,311	87.04
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—1–9 Years*	Admin	839,376	34,953	839,376	41.64
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—10–19 Years*	Admin	815,730	21,799	815,730	26.72
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—20–44 Years*	Admin	1,151,321	61,924	1,151,321	53.79
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—45–64 Years*	Admin	704,339	42,089	704,339	59.76
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—65–74 Years*	Admin	153,215	7,496	153,215	48.92
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—75–84 Years*	Admin	76,648	3,476	76,648	45.35
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—85+ Years*	Admin	36,293	1,720	36,293	47.39
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—Unknown*	Admin	0	0	0	NA
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—Total (1-19)*	Admin	1,751,417	65,135	1,751,417	37.19
QI	Statewide	AMBA	Ambulatory Care—Total	ED Visits—Total*	Admin	3,873,233	181,840	3,873,233	46.95
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—<1 Year	Admin	96,311	78,263	96,311	812.61
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—1–9 Years	Admin	839,376	232,834	839,376	277.39
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—10–19 Years	Admin	815,730	176,431	815,730	216.29
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—20–44 Years	Admin	1,151,321	342,037	1,151,321	297.08
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—45–64 Years	Admin	704,339	397,975	704,339	565.03
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—65–74 Years	Admin	153,215	113,349	153,215	739.80
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—75–84 Years	Admin	76,648	58,066	76,648	757.57
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—85+ Years	Admin	36,293	26,126	36,293	719.86
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—Unknown	Admin	0	0	0	NA
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—Total (1-19)	Admin	1,751,417	487,528	1,751,417	278.36
QI	Statewide	AMBA	Ambulatory Care—Total	Outpatient Visits—Total	Admin	3,873,233	1,425,081	3,873,233	367.93
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	514	268	514	52.14%
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	36	20	36	55.56%
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	550	288	550	52.36%
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	514	186	514	36.19%
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	36	14	36	38.89%
QI	AlohaCare	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	550	200	550	36.36%
QI	HSMA	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	1,619	800	1,619	49.41%
QI	HSMA	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	45	16	45	35.56%
QI	HSMA	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	1,664	816	1,664	49.04%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	1,619	571	1,619	35.27%
QI	HSMA	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	45	9	45	20.00%
QI	HSMA	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	1,664	580	1,664	34.86%
QI	KFHP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	243	167	243	68.72%
QI	KFHP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	16	11	16	NA
QI	KFHP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	259	178	259	68.73%
QI	KFHP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	243	108	243	44.44%
QI	KFHP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	16	10	16	NA
QI	KFHP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	259	118	259	45.56%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	362	172	362	47.51%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	45	34	45	75.56%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	407	206	407	50.61%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	362	118	362	32.60%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	45	26	45	57.78%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	407	144	407	35.38%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment	Admin	206	95	206	46.12%
QI	'Ohana	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment	Admin	206	63	206	30.58%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	521	275	521	52.78%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	167	113	167	67.66%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	688	388	688	56.40%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	521	200	521	38.39%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	167	87	167	52.10%
QI	UHCCP	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	688	287	688	41.72%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—18–64 Years	Admin	3,259	1,682	3,259	51.61%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—65+ Years	Admin	309	194	309	62.78%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Acute Phase Treatment—Total	Admin	3,568	1,876	3,568	52.58%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—18–64 Years	Admin	3,259	1,183	3,259	36.30%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—65+ Years	Admin	309	146	309	47.25%
QI	Statewide	AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment—Total	Admin	3,568	1,329	3,568	37.25%
QI	AlohaCare	AMR	Asthma Medication Ratio	5–11 Years	Admin	111	66	111	59.46%
QI	AlohaCare	AMR	Asthma Medication Ratio	12–18 Years	Admin	97	51	97	52.58%
QI	AlohaCare	AMR	Asthma Medication Ratio	19–50 Years	Admin	266	87	266	32.71%
QI	AlohaCare	AMR	Asthma Medication Ratio	51–64 Years	Admin	123	56	123	45.53%
QI	AlohaCare	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	208	117	208	56.25%
QI	AlohaCare	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	389	143	389	36.76%
QI	AlohaCare	AMR	Asthma Medication Ratio	Total	Admin	597	260	597	43.55%
QI	HSMA	AMR	Asthma Medication Ratio	5–11 Years	Admin	415	274	415	66.02%
QI	HSMA	AMR	Asthma Medication Ratio	12–18 Years	Admin	335	177	335	52.84%
QI	HSMA	AMR	Asthma Medication Ratio	19–50 Years	Admin	717	265	717	36.96%
QI	HSMA	AMR	Asthma Medication Ratio	51–64 Years	Admin	292	123	292	42.12%
QI	HSMA	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	750	451	750	60.13%
QI	HSMA	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	1,009	388	1,009	38.45%
QI	HSMA	AMR	Asthma Medication Ratio	Total	Admin	1,759	839	1,759	47.70%
QI	KFHP	AMR	Asthma Medication Ratio	5–11 Years	Admin	112	99	112	88.39%
QI	KFHP	AMR	Asthma Medication Ratio	12–18 Years	Admin	94	80	94	85.11%
QI	KFHP	AMR	Asthma Medication Ratio	19–50 Years	Admin	130	85	130	65.38%
QI	KFHP	AMR	Asthma Medication Ratio	51–64 Years	Admin	83	69	83	83.13%
QI	KFHP	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	206	179	206	86.89%

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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	213	154	213	72.30%
QI	KFHP	AMR	Asthma Medication Ratio	Total	Admin	419	333	419	79.47%
QI	'Ohana	AMR	Asthma Medication Ratio	5–11 Years	Admin	14	6	14	NA
QI	'Ohana	AMR	Asthma Medication Ratio	12–18 Years	Admin	21	10	21	NA
QI	'Ohana	AMR	Asthma Medication Ratio	19–50 Years	Admin	104	47	104	45.19%
QI	'Ohana	AMR	Asthma Medication Ratio	51–64 Years	Admin	98	43	98	43.88%
QI	'Ohana	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	35	16	35	45.71%
QI	'Ohana	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	202	90	202	44.55%
QI	'Ohana	AMR	Asthma Medication Ratio	Total	Admin	237	106	237	44.73%
QI	UHCCP	AMR	Asthma Medication Ratio	5–11 Years	Admin	15	10	15	NA
QI	UHCCP	AMR	Asthma Medication Ratio	12–18 Years	Admin	15	9	15	NA
QI	UHCCP	AMR	Asthma Medication Ratio	19–50 Years	Admin	140	68	140	48.57%
QI	UHCCP	AMR	Asthma Medication Ratio	51–64 Years	Admin	142	77	142	54.23%
QI	UHCCP	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	30	19	30	63.33%
QI	UHCCP	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	282	145	282	51.42%
QI	UHCCP	AMR	Asthma Medication Ratio	Total	Admin	312	164	312	52.56%
QI	Statewide	AMR	Asthma Medication Ratio	5–11 Years	Admin	667	455	667	68.22%
QI	Statewide	AMR	Asthma Medication Ratio	12–18 Years	Admin	562	327	562	58.19%
QI	Statewide	AMR	Asthma Medication Ratio	19–50 Years	Admin	1,357	552	1,357	40.68%
QI	Statewide	AMR	Asthma Medication Ratio	51–64 Years	Admin	738	368	738	49.86%
QI	Statewide	AMR	Asthma Medication Ratio	Total (5–18 Years)	Admin	1,229	782	1,229	63.63%
QI	Statewide	AMR	Asthma Medication Ratio	Total (19–64 Years)	Admin	2,095	920	2,095	43.91%
QI	Statewide	AMR	Asthma Medication Ratio	Total	Admin	3,324	1,702	3,324	51.20%
QI	AlohaCare	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Hybrid	11,637	207	411	50.36%
QI	HSMA	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Hybrid	31,700	245	410	59.76%
QI	KFHP	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Admin	5,879	2,662	5,879	45.28%
QI	'Ohana	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Hybrid	2,406	202	411	49.15%
QI	UHCCP	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Hybrid	3,316	193	411	46.96%
QI	Statewide	AWC	Adolescent Well-Care Visits	Adolescent Well-Care Visits	Mixed	54,938	—	—	54.98%
QI	AlohaCare	BCS	Breast Cancer Screening	50–64 Years	Admin	1,884	888	1,884	47.13%
QI	AlohaCare	BCS	Breast Cancer Screening	65–74 Years	Admin	614	289	614	47.07%
QI	AlohaCare	BCS	Breast Cancer Screening	Total	Admin	2,498	1,177	2,498	47.12%
QI	HSMA	BCS	Breast Cancer Screening	50–64 Years	Admin	6,520	4,065	6,520	62.35%
QI	HSMA	BCS	Breast Cancer Screening	65–74 Years	Admin	1,298	537	1,298	41.37%
QI	HSMA	BCS	Breast Cancer Screening	Total	Admin	7,818	4,602	7,818	58.86%
QI	KFHP	BCS	Breast Cancer Screening	50–64 Years	Admin	1,117	893	1,117	79.95%
QI	KFHP	BCS	Breast Cancer Screening	65–74 Years	Admin	279	236	279	84.59%
QI	KFHP	BCS	Breast Cancer Screening	Total	Admin	1,396	1,129	1,396	80.87%
QI	'Ohana	BCS	Breast Cancer Screening	50–64 Years	Admin	1,722	873	1,722	50.70%
QI	'Ohana	BCS	Breast Cancer Screening	65–74 Years	Admin	653	333	653	51.00%
QI	'Ohana	BCS	Breast Cancer Screening	Total	Admin	2,375	1,206	2,375	50.78%
QI	UHCCP	BCS	Breast Cancer Screening	50–64 Years	Admin	2,151	1,161	2,151	53.97%
QI	UHCCP	BCS	Breast Cancer Screening	65–74 Years	Admin	2,038	1,375	2,038	67.47%
QI	UHCCP	BCS	Breast Cancer Screening	Total	Admin	4,189	2,536	4,189	60.54%
QI	Statewide	BCS	Breast Cancer Screening	50–64 Years	Admin	13,394	7,880	13,394	58.83%
QI	Statewide	BCS	Breast Cancer Screening	65–74 Years	Admin	4,882	2,770	4,882	56.74%
QI	Statewide	BCS	Breast Cancer Screening	Total	Admin	18,276	10,650	18,276	58.27%
CCS	'Ohana	BHA	Behavioral Health Assessment	BHA Completion Within 14 Days of Enrollment (Within Standard)	Admin	700	280	700	40.00%
CCS	'Ohana	BHA	Behavioral Health Assessment	BHA Completion Within 30 Days of Enrollment (Within Standard)	Admin	700	118	700	16.86%
CCS	'Ohana	BHA	Behavioral Health Assessment	BHA Completion Within 31-60 Days of Enrollment (Not Within Standard)	Admin	700	53	700	7.57%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	1,083	1,043	1,083	96.31%
QI	AlohaCare	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	6,785	5,794	6,785	85.39%
QI	AlohaCare	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	6,817	5,885	6,817	86.33%
QI	AlohaCare	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	9,234	7,951	9,234	86.11%
QI	HSMA	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	3,510	3,397	3,510	96.78%
QI	HSMA	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	19,313	17,293	19,313	89.54%
QI	HSMA	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	18,639	16,878	18,639	90.55%
QI	HSMA	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	25,232	22,819	25,232	90.44%
QI	KFHP	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	758	749	758	98.81%
QI	KFHP	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	3,718	3,471	3,718	93.36%
QI	KFHP	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	3,478	3,183	3,478	91.52%
QI	KFHP	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	4,731	4,312	4,731	91.14%
QI	'Ohana	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	374	348	374	93.05%
QI	'Ohana	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	1,968	1,505	1,968	76.47%
QI	'Ohana	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	1,044	829	1,044	79.41%
QI	'Ohana	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	1,602	1,268	1,602	79.15%
QI	UHCCP	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	499	467	499	93.59%
QI	UHCCP	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	2,480	1,883	2,480	75.93%
QI	UHCCP	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	1,300	1,040	1,300	80.00%
QI	UHCCP	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	1,917	1,497	1,917	78.09%
QI	Statewide	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–24 Months	Admin	6,224	6,004	6,224	96.47%
QI	Statewide	CAP	Children and Adolescents' Access to Primary Care Practitioners	25 Months–6 Years	Admin	34,264	29,946	34,264	87.40%
QI	Statewide	CAP	Children and Adolescents' Access to Primary Care Practitioners	7–11 Years	Admin	31,278	27,815	31,278	88.93%
QI	Statewide	CAP	Children and Adolescents' Access to Primary Care Practitioners	12–19 Years	Admin	42,716	37,847	42,716	88.60%
QI	AlohaCare	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	3,526	191	325	58.77%
QI	AlohaCare	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	231	48	86	55.81%
QI	AlohaCare	CBP	Controlling High Blood Pressure	Total	Hybrid	3,757	239	411	58.15%
QI	HSMA	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	10,274	201	363	55.37%
QI	HSMA	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	1,581	23	47	48.94%
QI	HSMA	CBP	Controlling High Blood Pressure	Total	Hybrid	11,855	224	410	54.63%
QI	KFHP	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	1,088	172	221	77.83%
QI	KFHP	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	323	60	75	80.00%
QI	KFHP	CBP	Controlling High Blood Pressure	Total	Hybrid	1,411	232	296	78.38%
QI	'Ohana	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	2,783	157	268	58.58%
QI	'Ohana	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	1,398	79	120	65.83%
QI	'Ohana	CBP	Controlling High Blood Pressure	Total	Hybrid	4,181	236	388	60.82%
QI	UHCCP	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	3,634	121	185	65.41%
QI	UHCCP	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	4,459	173	226	76.55%
QI	UHCCP	CBP	Controlling High Blood Pressure	Total	Hybrid	8,093	294	411	71.53%
QI	Statewide	CBP	Controlling High Blood Pressure	18–64 Years	Hybrid	21,305	—	—	59.21%
QI	Statewide	CBP	Controlling High Blood Pressure	65–85 Years	Hybrid	7,992	—	—	68.75%
QI	Statewide	CBP	Controlling High Blood Pressure	Total	Hybrid	29,297	—	—	61.78%
QI	AlohaCare	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Hybrid	10,559	224	411	54.50%
QI	HSMA	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Hybrid	32,973	280	411	68.13%
QI	KFHP	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Admin	5,125	4,035	5,125	78.73%
QI	'Ohana	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Hybrid	5,644	188	411	45.74%
QI	UHCCP	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Hybrid	7,890	220	411	53.53%
QI	Statewide	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Mixed	62,191	—	—	62.80%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	3,039	246	411	59.85%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	3,039	241	411	58.64%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Hybrid	3,039	220	411	53.53%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Hybrid	2,480	129	330	39.09%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Hybrid	483	16	81	19.75%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Hybrid	2,963	145	411	35.28%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Hybrid	2,480	285	330	86.36%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Hybrid	483	77	81	95.06%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Hybrid	2,963	362	411	88.08%
QI	AlohaCare	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Hybrid	3,039	374	411	91.00%
QI	HSMA	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	6,823	243	411	59.12%
QI	HSMA	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	6,823	275	411	66.91%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Hybrid	6,823	196	411	47.69%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Hybrid	6,042	150	360	41.67%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Hybrid	781	16	51	31.37%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Hybrid	6,823	166	411	40.39%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Hybrid	6,042	309	360	85.83%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Hybrid	781	42	51	82.35%
QI	HSMA	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Hybrid	6,823	351	411	85.40%
QI	HSMA	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Hybrid	6,823	355	411	86.37%
QI	KFHP	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	1,362	330	411	80.29%
QI	KFHP	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	1,362	287	411	69.83%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Admin	1,362	837	1,362	61.45%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Admin	1,185	366	1,185	30.89%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Admin	177	29	177	16.38%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Admin	1,362	395	1,362	29.00%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Admin	1,185	1,125	1,185	94.94%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Admin	177	169	177	95.48%
QI	KFHP	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Admin	1,362	1,294	1,362	95.01%
QI	KFHP	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Admin	1,362	1,304	1,362	95.74%
QI	'Ohana	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	2,461	259	411	63.02%
QI	'Ohana	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	2,461	269	411	65.45%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Hybrid	2,461	212	411	51.58%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Hybrid	1,928	135	303	44.55%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Hybrid	533	28	108	25.93%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Hybrid	2,461	163	411	39.66%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Hybrid	1,928	262	303	86.47%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Hybrid	533	100	108	92.59%
QI	'Ohana	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Hybrid	2,461	362	411	88.08%
QI	'Ohana	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Hybrid	2,461	376	411	91.48%
QI	UHCCP	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	3,959	277	411	67.40%
QI	UHCCP	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	3,959	290	411	70.56%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Hybrid	3,959	247	411	60.10%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Hybrid	2,449	90	249	36.14%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Hybrid	1,498	30	162	18.52%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Hybrid	3,947	120	411	29.20%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Hybrid	2,449	215	249	86.35%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Hybrid	1,498	153	162	94.44%
QI	UHCCP	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Hybrid	3,947	368	411	89.54%
QI	UHCCP	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Hybrid	3,959	390	411	94.89%
QI	Statewide	CDC	Comprehensive Diabetes Care	Blood Pressure Control (<140/90 mm Hg)	Hybrid	17,644	—	—	63.28%
QI	Statewide	CDC	Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	Hybrid	17,644	—	—	66.33%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Control (<8.0%)	Mixed	17,644	—	—	53.08%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 18-64 Years*	Mixed	14,084	—	—	39.74%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) 65-75 Years*	Mixed	3,472	—	—	22.61%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Poor Control (>9.0%) Total*	Mixed	17,556	—	—	36.02%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Testing 18-64 Years	Mixed	14,084	—	—	86.87%
QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Testing 65-75 Years	Mixed	3,472	—	—	91.58%

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QI	Statewide	CDC	Comprehensive Diabetes Care	HbA1c Testing Total	Mixed	17,556	—	—	87.90%
QI	Statewide	CDC	Comprehensive Diabetes Care	Medical Attention for Nephropathy	Mixed	17,644	—	—	90.52%
QI	AlohaCare	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	7,229	1,198	6,918	17.32%
QI	AlohaCare	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	18,666	1,315	18,666	7.04%
QI	AlohaCare	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	2,130	256	2,130	12.02%
QI	HSMA	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	18,957	8,544	18,957	45.07%
QI	HSMA	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	54,302	14,505	54,302	26.71%
QI	HSMA	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	3,160	852	3,160	26.96%
QI	KFHP	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	3,503	58	3,503	1.66%
QI	KFHP	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	9,464	1,407	9,464	14.87%
QI	KFHP	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	836	82	836	9.81%
QI	'Ohana	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	1,330	154	1,330	11.58%
QI	'Ohana	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	10,663	847	10,661	7.94%
QI	'Ohana	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	3,354	868	3,351	25.90%
QI	UHCCP	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	1,761	190	1,761	10.79%
QI	UHCCP	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	15,127	1,095	15,124	7.24%
QI	UHCCP	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	8,076	1,911	8,074	23.67%
QI	Statewide	CDF	Screening for Depression and Follow-Up Plan	12–17 Years	Admin	32,780	10,144	32,469	31.24%
QI	Statewide	CDF	Screening for Depression and Follow-Up Plan	18–64 Years	Admin	108,222	19,169	108,217	17.71%
QI	Statewide	CDF	Screening for Depression and Follow-Up Plan	65+ Years	Admin	17,556	3,969	17,551	22.61%
QI	AlohaCare	CHL	Chlamydia Screening in Women	16–20 Years	Admin	1,033	381	1,033	36.88%
QI	AlohaCare	CHL	Chlamydia Screening in Women	21–24 Years	Admin	783	352	783	44.96%
QI	AlohaCare	CHL	Chlamydia Screening in Women	Total	Admin	1,816	733	1,816	40.36%
QI	HSMA	CHL	Chlamydia Screening in Women	16–20 Years	Admin	2,989	1,442	2,989	48.24%
QI	HSMA	CHL	Chlamydia Screening in Women	21–24 Years	Admin	2,570	1,412	2,570	54.94%
QI	HSMA	CHL	Chlamydia Screening in Women	Total	Admin	5,559	2,854	5,559	51.34%
QI	KFHP	CHL	Chlamydia Screening in Women	16–20 Years	Admin	596	457	596	76.68%
QI	KFHP	CHL	Chlamydia Screening in Women	21–24 Years	Admin	450	387	450	86.00%
QI	KFHP	CHL	Chlamydia Screening in Women	Total	Admin	1,046	844	1,046	80.69%
QI	'Ohana	CHL	Chlamydia Screening in Women	16–20 Years	Admin	168	58	168	34.52%
QI	'Ohana	CHL	Chlamydia Screening in Women	21–24 Years	Admin	201	103	201	51.24%
QI	'Ohana	CHL	Chlamydia Screening in Women	Total	Admin	369	161	369	43.63%
QI	UHCCP	CHL	Chlamydia Screening in Women	16–20 Years	Admin	238	99	238	41.60%
QI	UHCCP	CHL	Chlamydia Screening in Women	21–24 Years	Admin	366	179	366	48.91%
QI	UHCCP	CHL	Chlamydia Screening in Women	Total	Admin	604	278	604	46.03%
QI	Statewide	CHL	Chlamydia Screening in Women	16–20 Years	Admin	5,024	2,437	5,024	48.51%
QI	Statewide	CHL	Chlamydia Screening in Women	21–24 Years	Admin	4,370	2,433	4,370	55.68%
QI	Statewide	CHL	Chlamydia Screening in Women	Total	Admin	9,394	4,870	9,394	51.84%
QI	AlohaCare	CIS	Childhood Immunization Status	DTaP	Hybrid	1,037	287	411	69.83%
QI	AlohaCare	CIS	Childhood Immunization Status	IPV	Hybrid	1,037	335	411	81.51%
QI	AlohaCare	CIS	Childhood Immunization Status	MMR	Hybrid	1,037	339	411	82.48%
QI	AlohaCare	CIS	Childhood Immunization Status	HiB	Hybrid	1,037	334	411	81.27%
QI	AlohaCare	CIS	Childhood Immunization Status	Hepatitis B	Hybrid	1,037	337	411	82.00%
QI	AlohaCare	CIS	Childhood Immunization Status	VZV	Hybrid	1,037	335	411	81.51%
QI	AlohaCare	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Hybrid	1,037	284	411	69.10%
QI	AlohaCare	CIS	Childhood Immunization Status	Combination 3	Hybrid	1,037	265	411	64.48%
QI	HSMA	CIS	Childhood Immunization Status	DTaP	Hybrid	3,344	305	411	74.21%
QI	HSMA	CIS	Childhood Immunization Status	IPV	Hybrid	3,344	342	411	83.21%
QI	HSMA	CIS	Childhood Immunization Status	MMR	Hybrid	3,344	365	411	88.81%
QI	HSMA	CIS	Childhood Immunization Status	HiB	Hybrid	3,344	360	411	87.59%
QI	HSMA	CIS	Childhood Immunization Status	Hepatitis B	Hybrid	3,344	330	411	80.29%
QI	HSMA	CIS	Childhood Immunization Status	VZV	Hybrid	3,344	359	411	87.35%
QI	HSMA	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Hybrid	3,344	311	411	75.67%

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QI	HSMA	CIS	Childhood Immunization Status	Combination 3	Hybrid	3,344	271	411	65.94%
QI	KFHP	CIS	Childhood Immunization Status	DTaP	Admin	686	566	686	82.51%
QI	KFHP	CIS	Childhood Immunization Status	IPV	Admin	686	621	686	90.52%
QI	KFHP	CIS	Childhood Immunization Status	MMR	Admin	686	626	686	91.25%
QI	KFHP	CIS	Childhood Immunization Status	HiB	Admin	686	599	686	87.32%
QI	KFHP	CIS	Childhood Immunization Status	Hepatitis B	Admin	686	623	686	90.82%
QI	KFHP	CIS	Childhood Immunization Status	VZV	Admin	686	621	686	90.52%
QI	KFHP	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Admin	686	549	686	80.03%
QI	KFHP	CIS	Childhood Immunization Status	Combination 3	Admin	686	545	686	79.45%
QI	'Ohana	CIS	Childhood Immunization Status	DTaP	Hybrid	322	199	319	62.38%
QI	'Ohana	CIS	Childhood Immunization Status	IPV	Hybrid	322	239	319	74.92%
QI	'Ohana	CIS	Childhood Immunization Status	MMR	Hybrid	322	239	319	74.92%
QI	'Ohana	CIS	Childhood Immunization Status	HiB	Hybrid	322	239	319	74.92%
QI	'Ohana	CIS	Childhood Immunization Status	Hepatitis B	Hybrid	322	234	319	73.35%
QI	'Ohana	CIS	Childhood Immunization Status	VZV	Hybrid	322	232	319	72.73%
QI	'Ohana	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Hybrid	322	193	319	60.50%
QI	'Ohana	CIS	Childhood Immunization Status	Combination 3	Hybrid	322	180	319	56.43%
QI	UHCCP	CIS	Childhood Immunization Status	DTaP	Hybrid	400	271	398	68.09%
QI	UHCCP	CIS	Childhood Immunization Status	IPV	Hybrid	400	320	398	80.40%
QI	UHCCP	CIS	Childhood Immunization Status	MMR	Hybrid	400	326	398	81.91%
QI	UHCCP	CIS	Childhood Immunization Status	HiB	Hybrid	400	320	398	80.40%
QI	UHCCP	CIS	Childhood Immunization Status	Hepatitis B	Hybrid	400	323	398	81.16%
QI	UHCCP	CIS	Childhood Immunization Status	VZV	Hybrid	400	322	398	80.90%
QI	UHCCP	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Hybrid	400	271	398	68.09%
QI	UHCCP	CIS	Childhood Immunization Status	Combination 3	Hybrid	400	251	398	63.07%
QI	Statewide	CIS	Childhood Immunization Status	DTaP	Mixed	5,789	—	—	73.33%
QI	Statewide	CIS	Childhood Immunization Status	IPV	Mixed	5,789	—	—	83.12%
QI	Statewide	CIS	Childhood Immunization Status	MMR	Mixed	5,789	—	—	86.72%
QI	Statewide	CIS	Childhood Immunization Status	HiB	Mixed	5,789	—	—	85.22%
QI	Statewide	CIS	Childhood Immunization Status	Hepatitis B	Mixed	5,789	—	—	81.52%
QI	Statewide	CIS	Childhood Immunization Status	VZV	Mixed	5,789	—	—	85.42%
QI	Statewide	CIS	Childhood Immunization Status	Pneumococcal Conjugate	Mixed	5,789	—	—	73.64%
QI	Statewide	CIS	Childhood Immunization Status	Combination 3	Mixed	5,789	—	—	66.55%
QI	AlohaCare	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	5,545	1,597	5,528	28.89%
QI	HSMA	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	16,770	8,231	16,770	49.08%
QI	KFHP	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	3,025	2,150	3,025	71.07%
QI	'Ohana	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	5,572	2,209	5,572	39.64%
QI	UHCCP	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	9,376	4,919	9,345	52.64%
QI	Statewide	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	Admin	40,288	19,106	40,240	47.48%
QI	AlohaCare	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	758,216	370,718	758,216	48.89%
QI	AlohaCare	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	758,216	224,714	758,216	29.64%
QI	AlohaCare	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	758,216	123,365	758,216	16.27%
QI	AlohaCare	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	758,216	39,419	758,216	5.20%
QI	HSMA	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	1,901,869	971,682	1,901,869	51.09%
QI	HSMA	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	1,901,869	569,428	1,901,869	29.94%
QI	HSMA	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	1,901,869	310,294	1,901,869	16.32%
QI	HSMA	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	1,901,869	50,465	1,901,869	2.65%
QI	KFHP	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	333,890	186,467	333,890	55.85%
QI	KFHP	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	333,890	85,515	333,890	25.61%
QI	KFHP	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	333,890	50,824	333,890	15.22%
QI	KFHP	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	333,890	11,084	333,890	3.32%
QI	'Ohana	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	342,755	93,583	342,755	27.30%
QI	'Ohana	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	342,755	109,838	342,755	32.05%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	342,755	93,002	342,755	27.13%
QI	'Ohana	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	342,755	46,332	342,755	13.52%
QI	UHCCP	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	540,567	129,075	540,567	23.88%
QI	UHCCP	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	540,567	162,168	540,567	30.00%
QI	UHCCP	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	540,567	125,899	540,567	23.29%
QI	UHCCP	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	540,567	123,425	540,567	22.83%
QI	Statewide	ENPA	Enrollment by Product Line	Enr by Product Line 0-19 SubTot Pct Tot	Admin	3,877,297	1,751,525	3,877,297	45.17%
QI	Statewide	ENPA	Enrollment by Product Line	Enr by Product Line 20-44 SubTot Pct Tot	Admin	3,877,297	1,151,663	3,877,297	29.70%
QI	Statewide	ENPA	Enrollment by Product Line	Enr by Product Line 45-64 SubTot Pct Tot	Admin	3,877,297	703,384	3,877,297	18.14%
QI	Statewide	ENPA	Enrollment by Product Line	Enr by Product Line 65+ SubTot Pct Tot	Admin	3,877,297	270,725	3,877,297	6.98%
QI	AlohaCare	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Admin	652	486	567	85.71%
QI	AlohaCare	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Admin	524	400	462	86.58%
QI	HSMA	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Admin	534	0	534	0.00%
QI	HSMA	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Admin	297	0	297	0.00%
QI	KFHP	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Admin	52	6	52	11.54%
QI	KFHP	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Admin	248	89	215	41.40%
QI	'Ohana	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Admin	3,994	1,265	3,994	31.67%
QI	'Ohana	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Admin	4,989	459	4,989	9.20%
QI	UHCCP	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Hybrid	3,306	223	336	66.37%
QI	UHCCP	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Hybrid	32,434	92	411	22.38%
QI	Statewide	FALLS1	Falls: Screening for Future Fall Risk	LTSS Population	Mixed	8,538	—	—	46.74%
QI	Statewide	FALLS1	Falls: Screening for Future Fall Risk	65+ Years	Mixed	38,492	—	—	21.38%
QI	AlohaCare	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	35	29	29	NA
QI	AlohaCare	FALLS2	Falls: Risk Assessment	65+ Years	Admin	28	25	25	NA
QI	HSMA	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	6	0	6	NA
QI	HSMA	FALLS2	Falls: Risk Assessment	65+ Years	Admin	6	0	6	NA
QI	KFHP	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	8	0	8	NA
QI	KFHP	FALLS2	Falls: Risk Assessment	65+ Years	Admin	12	0	12	NA
QI	'Ohana	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	230	116	230	50.43%
QI	'Ohana	FALLS2	Falls: Risk Assessment	65+ Years	Admin	81	36	81	44.44%
QI	UHCCP	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	1,736	12	1,621	0.74%
QI	UHCCP	FALLS2	Falls: Risk Assessment	65+ Years	Admin	9,448	41	8,195	0.50%
QI	Statewide	FALLS2	Falls: Risk Assessment	LTSS Population	Admin	2,015	157	1,894	8.29%
QI	Statewide	FALLS2	Falls: Risk Assessment	65+ Years	Admin	9,575	102	8,319	1.23%
QI	AlohaCare	FALLS3	Falls: Plan of Care	LTSS Population	Admin	35	3	29	NA
QI	AlohaCare	FALLS3	Falls: Plan of Care	65+ Years	Admin	28	2	25	NA
QI	HSMA	FALLS3	Falls: Plan of Care	LTSS Population	Admin	6	1	6	NA
QI	HSMA	FALLS3	Falls: Plan of Care	65+ Years	Admin	6	1	6	NA
QI	KFHP	FALLS3	Falls: Plan of Care	LTSS Population	Admin	8	0	8	NA
QI	KFHP	FALLS3	Falls: Plan of Care	65+ Years	Admin	12	0	12	NA
QI	'Ohana	FALLS3	Falls: Plan of Care	LTSS Population	Admin	230	89	230	38.70%
QI	'Ohana	FALLS3	Falls: Plan of Care	65+ Years	Admin	81	33	81	40.74%
QI	UHCCP	FALLS3	Falls: Plan of Care	LTSS Population	Admin	26	3	26	NA
QI	UHCCP	FALLS3	Falls: Plan of Care	65+ Years	Admin	151	26	151	17.22%
QI	Statewide	FALLS3	Falls: Plan of Care	LTSS Population	Admin	305	96	299	32.11%
QI	Statewide	FALLS3	Falls: Plan of Care	65+ Years	Admin	278	62	275	22.55%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	36	3	36	8.33%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	504	143	504	28.37%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	11	2	11	NA
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	515	145	515	28.16%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	551	148	551	26.86%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	36	3	36	8.33%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	504	88	504	17.46%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	11	1	11	NA
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	515	89	515	17.28%
QI	AlohaCare	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	551	92	551	16.70%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	58	4	58	6.90%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	838	205	838	24.46%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	19	3	19	NA
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	857	208	857	24.27%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	915	212	915	23.17%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	58	6	58	10.34%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	838	271	838	32.34%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	19	3	19	NA
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	857	274	857	31.97%
QI	HSMA	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	915	280	915	30.60%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	5	0	5	NA
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	67	14	67	20.90%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	0	0	0	NA
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	67	14	67	20.90%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	72	14	72	19.44%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	5	0	5	NA
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	67	8	67	11.94%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	0	0	0	NA
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	67	8	67	11.94%
QI	KFHP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	72	8	72	11.11%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	5	0	5	NA
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	315	54	315	17.14%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	11	0	11	NA
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	326	55	326	16.87%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	331	55	331	16.62%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	5	0	5	NA
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	315	33	315	10.48%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	11	0	11	NA
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	326	33	326	10.12%
QI	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	331	33	331	9.97%
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	194	32	194	16.49%
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	194	32	194	16.49%
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	194	20	194	10.31%
CCS	'Ohana	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	194	20	194	10.31%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	10	0	10	NA
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	500	84	500	16.80%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	22	4	22	NA
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	522	88	522	16.86%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	532	88	532	16.54%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	10	0	10	NA
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	500	49	500	9.80%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	22	3	22	NA
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	522	52	522	9.96%
QI	UHCCP	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	532	52	532	9.77%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—13–17 Years	Admin	114	7	114	6.14%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18–64 Years	Admin	2,224	500	2,224	22.48%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—65+ Years	Admin	63	9	63	14.29%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—18+ Years	Admin	2,287	510	2,287	22.30%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	30-Day Follow-Up—Total	Admin	2,401	517	2,401	21.53%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—13–17 Years	Admin	114	9	114	7.89%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18–64 Years	Admin	2,224	449	2,224	20.19%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—65+ Years	Admin	63	7	63	11.11%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—18+ Years	Admin	2,287	456	2,287	19.94%
QI	Statewide	FUA	Follow-Up After ED Visit for AOD Abuse or Dependence	7-Day Follow-Up—Total	Admin	2,401	465	2,401	19.37%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	57	29	57	50.88%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	265	98	265	36.98%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	8	1	8	NA
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	330	128	330	38.79%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	57	16	57	28.07%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	265	46	265	17.36%
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	8	1	8	NA
QI	AlohaCare	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	330	63	330	19.09%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	218	147	218	67.43%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	431	243	431	56.38%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	10	3	10	NA
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	659	393	659	59.64%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	218	108	218	49.54%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	431	146	431	33.87%
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	10	1	10	NA
QI	HSMA	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	659	255	659	38.69%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	47	36	47	76.60%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	81	59	81	72.84%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	3	1	3	NA
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	131	96	131	73.28%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	47	30	47	63.83%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	81	48	81	59.26%
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	3	1	3	NA
QI	KFHP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	131	79	131	60.31%
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	27	14	27	NA
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	198	107	198	54.04%
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	4	1	4	NA
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	229	122	229	53.28%
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	27	10	27	NA
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	198	65	198	32.83%
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	4	1	4	NA
QI	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	229	76	229	33.19%
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	433	320	433	73.90%
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	22	11	22	NA
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	455	331	455	72.75%
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	433	234	433	54.04%
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	22	6	22	NA
CCS	'Ohana	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	455	240	455	52.75%
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	16	7	16	NA
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	296	139	296	46.96%
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	21	12	21	NA
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	333	158	333	47.45%
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	16	5	16	NA
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	296	95	296	32.09%
QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	21	8	21	NA

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QI	UHCCP	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	333	108	333	32.43%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	365	233	365	63.84%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	1,271	646	1271	50.83%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—65+ Years	Admin	46	18	46	39.13%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	30-Day Follow-Up—Total	Admin	1,682	897	1,682	53.33%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	365	169	365	46.30%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	1,271	400	1,271	31.47%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—65+ Years	Admin	46	12	46	26.09%
QI	Statewide	FUH	Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up—Total	Admin	1,682	581	1,682	34.54%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	60	28	60	46.67%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	351	143	351	40.74%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	6	3	6	NA
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	417	174	417	41.73%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	60	16	60	26.67%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	351	80	351	22.79%
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	6	2	6	NA
QI	AlohaCare	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	417	98	417	23.50%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	126	81	126	64.29%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	451	222	451	49.22%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	7	2	7	NA
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	584	305	584	52.23%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	126	56	126	44.44%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	451	144	451	31.93%
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	7	1	7	NA
QI	HSMA	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	584	201	584	34.42%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	37	27	37	72.97%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	84	43	84	51.19%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	1	0	1	NA
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	122	70	122	57.38%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	37	17	37	45.95%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	84	29	84	34.52%
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	1	0	1	NA
QI	KFHP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	122	46	122	37.70%
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	14	8	14	NA
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	233	97	233	41.63%
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	11	6	11	NA
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	258	111	258	43.02%
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	14	6	14	NA
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	233	52	233	22.32%
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	11	4	11	NA
QI	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	258	62	258	24.03%
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	376	248	376	65.96%
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	24	14	24	NA
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	400	262	400	65.50%
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	0	0	0	NA
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	376	166	376	44.15%
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	24	12	24	NA
CCS	'Ohana	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	400	178	400	44.50%
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	19	8	19	NA
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	420	153	420	36.43%
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	26	7	26	NA
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	465	168	465	36.13%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	19	4	19	NA
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	420	96	420	22.86%
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	26	5	26	NA
QI	UHCCP	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	465	105	465	22.58%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—6–17 Years	Admin	256	152	256	59.38%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—18–64 Years	Admin	1,539	658	1,539	42.76%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—65+ Years	Admin	51	18	51	35.29%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	30-Day Follow-Up—Total	Admin	1,846	828	1,846	44.85%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—6–17 Years	Admin	256	99	256	38.67%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—18–64 Years	Admin	1,539	401	1,539	26.06%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—65+ Years	Admin	51	12	51	23.53%
QI	Statewide	FUM	Follow-Up After ED Visit for Mental Illness	7-Day Follow-Up—Total	Admin	1,846	512	1,846	27.74%
QI	AlohaCare	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	241	62	241	25.73%
QI	HSMA	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	433	164	433	37.88%
QI	KFHP	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	77	17	77	22.08%
QI	'Ohana	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	178	44	178	24.72%
QI	UHCCP	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	356	180	356	50.56%
QI	Statewide	FUP	Follow-Up With a PCP After Hospitalization for Mental Illness	Follow-Up With a PCP After Hospitalization for Mental Illness	Admin	1,285	467	1285	36.34%
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	1,808	20	1808	11.06
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	26	20	26	0.78
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	1,806	45	1806	24.92
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	28	45	28	1.59
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	1,806	65	1806	35.99
QI	AlohaCare	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	48	65	48	1.34
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,542	22	2542	8.65
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	32	22	32	0.68
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,542	51	2542	20.06
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	35	51	35	1.48
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,542	73	2542	28.72
QI	HSMA	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	62	73	62	1.18
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	679	13	679	19.15
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	17	13	17	0.76

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	679	14	679	20.62
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	17	14	17	0.83
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	680	27	680	39.71
QI	KFHP	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	28	27	28	0.95
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,789	31	2789	11.12
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	59	31	59	0.53
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,788	59	2788	21.16
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	63	59	63	0.93
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	2,789	90	2789	32.27
QI	'Ohana	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	108	90	108	0.83
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	8,402	117	8402	13.93
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	149	117	149	0.79
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	8,386	169	8386	20.15
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	152	169	152	1.11
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	8,386	283	8386	33.75
QI	UHCCP	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	268	283	268	1.06
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Acute ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	16,220	203	16220	12.52
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Acute Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	283	203	283	0.72
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Chronic ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	16,201	338	16201	20.86
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Chronic Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	295	338	295	1.15
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Total ACSC—Observed Discharges per 1,000 Non-Outlier Members—Total—Total	Admin	16,203	538	16203	33.20
QI	Statewide	HPC	Hospitalization for Potentially Preventable Complications	Total Ambulatory Care Sensitive Conditions—O/E Ratio—Total—Total	Admin	514	538	514	1.05
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	35	13	35	37.14%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	636	242	636	38.05%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	592	225	592	38.01%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	44	17	44	38.64%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	671	255	671	38.00%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	195	71	195	36.41%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	180	67	180	37.22%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	15	4	15	NA
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	195	71	195	36.41%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	76	32	76	42.11%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	1,310	568	1310	43.36%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	1,278	558	1278	43.66%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	32	10	32	31.25%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	1,386	600	1386	43.29%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	102	38	102	37.25%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	1,963	793	1963	40.40%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	1,876	765	1876	40.78%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	87	28	87	32.18%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	2,065	831	2065	40.24%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	35	4	35	11.43%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	636	72	636	11.32%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	592	72	592	12.16%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	44	0	44	0.00%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	671	76	671	11.33%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	195	27	195	13.85%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	180	25	180	13.89%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	15	2	15	NA
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	195	27	195	13.85%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	76	15	76	19.74%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	1,310	151	1310	11.53%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	1,278	149	1278	11.66%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	32	2	32	6.25%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	1,386	166	1386	11.98%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	102	16	102	15.69%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	1,963	224	1963	11.41%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	1,876	220	1876	11.73%
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	87	4	87	4.60%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	2,065	240	2065	11.62%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	48	22	48	45.83%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	1,223	444	1223	36.30%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	1,156	423	1156	36.59%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	67	21	67	31.34%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	1,271	466	1271	36.66%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	3	1	3	NA
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	473	173	473	36.58%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	429	167	429	38.93%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	44	6	44	13.64%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	476	174	476	36.55%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	217	99	217	45.62%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	2,252	927	2252	41.16%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	2,189	902	2189	41.21%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	63	25	63	39.68%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	2,469	1,026	2469	41.56%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	250	110	250	44.00%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	3,676	1,406	3676	38.25%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	3,513	1,359	3513	38.68%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	163	47	163	28.83%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	3,926	1,516	3926	38.61%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	48	7	48	14.58%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	1,223	179	1223	14.64%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	1,156	177	1156	15.31%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	67	2	67	2.99%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	1,271	186	1271	14.63%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	3	1	3	NA
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	473	83	473	17.55%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	429	81	429	18.88%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	44	2	44	4.55%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	476	84	476	17.65%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	217	50	217	23.04%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	2,252	392	2252	17.41%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	2,189	389	2189	17.77%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	63	3	63	4.76%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	2,469	442	2469	17.90%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	250	54	250	21.60%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	3,676	586	3676	15.94%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	3,513	579	3513	16.48%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	163	7	163	4.29%
QI	HSMA	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	3,926	640	3926	16.30%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	4	3	4	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	150	65	150	43.33%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	146	64	146	43.84%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	4	1	4	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	154	68	154	44.16%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	33	11	33	33.33%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	29	11	29	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	3	0	3	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	33	11	33	33.33%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	35	11	35	31.43%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	251	101	251	40.24%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	245	101	245	41.22%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	3	1	3	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	286	112	286	39.16%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	36	12	36	33.33%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	406	166	406	40.89%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	392	164	392	41.84%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	10	2	10	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	442	178	442	40.27%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	4	1	4	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	150	12	150	8.00%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	146	12	146	8.22%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	4	0	4	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	154	13	154	8.44%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	33	1	33	3.03%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	29	1	29	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	3	0	3	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	33	1	33	3.03%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	35	2	35	5.71%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	251	26	251	10.36%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	245	26	245	10.61%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	3	0	3	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	286	28	286	9.79%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	36	2	36	5.56%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	406	37	406	9.11%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	392	37	392	9.44%
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	10	0	10	NA
QI	KFHP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	442	39	442	8.82%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	3	2	3	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	429	164	429	38.23%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	358	134	358	37.43%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	69	25	69	36.23%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	432	166	432	38.43%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	1	1	1	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	159	47	159	29.56%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	136	43	136	31.62%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	22	4	22	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	160	48	160	30.00%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	17	12	17	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	817	342	817	41.86%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	778	319	778	41.00%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	39	17	39	43.59%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	834	354	834	42.45%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	19	13	19	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	1,288	504	1288	39.13%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	1,170	454	1170	38.80%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	120	41	120	34.17%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	1,307	517	1307	39.56%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	3	1	3	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	429	30	429	6.99%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	358	29	358	8.10%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	69	4	69	5.80%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	432	31	432	7.18%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	1	0	1	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	159	21	159	13.21%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	136	20	136	14.71%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	22	1	22	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	160	21	160	13.13%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	17	6	17	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	817	99	817	12.12%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	778	102	778	13.11%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	39	2	39	5.13%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	834	105	834	12.59%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	19	6	19	NA
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	1,288	138	1288	10.71%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	1,170	141	1170	12.05%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	120	6	120	5.00%
QI	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	1,307	144	1307	11.02%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	170	70	170	41.18%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	170	70	170	41.18%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	52	18	52	34.62%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	52	18	52	34.62%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	383	179	383	46.74%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	383	179	383	46.74%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	563	246	563	43.69%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	563	246	563	43.69%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	0	0	0	NA

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	170	22	170	12.94%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	170	22	170	12.94%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	52	3	52	5.77%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	52	3	52	5.77%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	383	40	383	10.44%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	383	40	383	10.44%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	0	0	0	NA
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	563	61	563	10.83%
CCS	'Ohana	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	563	61	563	10.83%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	7	1	7	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	651	233	651	35.79%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	530	198	530	37.36%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	121	35	121	28.93%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	658	234	658	35.56%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	270	100	270	37.04%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	201	76	201	37.81%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	69	24	69	34.78%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	270	100	270	37.04%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	6	2	6	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	1,118	452	1118	40.43%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	1,046	429	1046	41.01%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	72	23	72	31.94%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	1,124	454	1124	40.39%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	11	3	11	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	1,891	709	1891	37.49%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	1,633	628	1633	38.46%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	258	81	258	31.40%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	1,902	712	1902	37.43%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	7	0	7	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	651	78	651	11.98%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	530	72	530	13.58%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	121	6	121	4.96%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	658	78	658	11.85%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	0	0	0	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	270	27	270	10.00%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	201	26	201	12.94%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	69	1	69	1.45%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	270	27	270	10.00%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	6	1	6	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	1,118	141	1118	12.61%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	1,046	135	1046	12.91%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	72	6	72	8.33%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	1,124	142	1124	12.63%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	11	1	11	NA
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	1,891	217	1891	11.48%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	1,633	204	1633	12.49%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	258	13	258	5.04%
QI	UHCCP	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	1,902	218	1902	11.46%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—13–17 Years	Admin	97	41	97	42.27%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18+ Years	Admin	3,089	1,148	3089	37.16%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—18–64 Years	Admin	2,782	1,044	2782	37.53%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—65+ Years	Admin	305	99	305	32.46%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Alcohol Abuse or Dependence—Total	Admin	3,186	1,189	3186	37.32%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—13–17 Years	Admin	4	2	4	NA
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18+ Years	Admin	1,130	402	1130	35.58%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—18–64 Years	Admin	975	364	975	37.33%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—65+ Years	Admin	153	38	153	24.84%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Opioid Abuse or Dependence—Total	Admin	1,134	404	1134	35.63%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—13–17 Years	Admin	351	156	351	44.44%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18+ Years	Admin	5,748	2,390	5748	41.58%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—18–64 Years	Admin	5,536	2,309	5536	41.71%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—65+ Years	Admin	209	76	209	36.36%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Other Drug Abuse or Dependence—Total	Admin	6,099	2,546	6099	41.74%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—13–17 Years	Admin	418	176	418	42.11%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18+ Years	Admin	9,224	3,578	9224	38.79%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—18–64 Years	Admin	8,584	3,370	8584	39.26%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—65+ Years	Admin	638	199	638	31.19%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation—Total—Total	Admin	9,642	3,754	9642	38.93%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—13–17 Years	Admin	97	13	97	13.40%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18+ Years	Admin	3,089	371	3089	12.01%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—18–64 Years	Admin	2,782	362	2782	13.01%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—65+ Years	Admin	305	12	305	3.93%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Alcohol Abuse or Dependence—Total	Admin	3,186	384	3186	12.05%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—13–17 Years	Admin	4	1	4	NA
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18+ Years	Admin	1,130	159	1130	14.07%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—18–64 Years	Admin	975	153	975	15.69%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—65+ Years	Admin	153	6	153	3.92%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Opioid Abuse or Dependence—Total	Admin	1,134	160	1134	14.11%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—13–17 Years	Admin	351	74	351	21.08%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18+ Years	Admin	5,748	809	5748	14.07%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—18–64 Years	Admin	5,536	801	5536	14.47%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—65+ Years	Admin	209	13	209	6.22%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Other Drug Abuse or Dependence—Total	Admin	6,099	883	6099	14.48%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—13–17 Years	Admin	418	79	418	18.90%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18+ Years	Admin	9,224	1,202	9224	13.03%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—18–64 Years	Admin	8,584	1,181	8584	13.76%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—65+ Years	Admin	638	30	638	4.70%
QI	Statewide	IET	Initiation and Engagement of AOD Abuse or Dependence Treatment	Engagement—Total—Total	Admin	9,642	1,281	9642	13.29%
QI	AlohaCare	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Hybrid	1,443	223	411	54.26%
QI	AlohaCare	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Hybrid	1,443	85	411	20.68%
QI	AlohaCare	IMA	Immunizations for Adolescents	HPV	Hybrid	1,443	105	411	25.55%
QI	AlohaCare	IMA	Immunizations for Adolescents	Meningococcal	Hybrid	1,443	234	411	56.93%
QI	AlohaCare	IMA	Immunizations for Adolescents	Tdap	Hybrid	1,443	258	411	62.77%
QI	HSMA	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Hybrid	3,721	285	411	69.34%
QI	HSMA	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Hybrid	3,721	136	411	33.09%
QI	HSMA	IMA	Immunizations for Adolescents	HPV	Hybrid	3,721	149	411	36.25%
QI	HSMA	IMA	Immunizations for Adolescents	Meningococcal	Hybrid	3,721	293	411	71.29%
QI	HSMA	IMA	Immunizations for Adolescents	Tdap	Hybrid	3,721	315	411	76.64%
QI	KFHP	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Admin	751	625	751	83.22%
QI	KFHP	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Admin	751	330	751	43.94%
QI	KFHP	IMA	Immunizations for Adolescents	HPV	Admin	751	337	751	44.87%
QI	KFHP	IMA	Immunizations for Adolescents	Meningococcal	Admin	751	633	751	84.29%
QI	KFHP	IMA	Immunizations for Adolescents	Tdap	Admin	751	641	751	85.35%
QI	'Ohana	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Hybrid	246	126	246	51.22%

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QI	'Ohana	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Hybrid	246	57	246	23.17%
QI	'Ohana	IMA	Immunizations for Adolescents	HPV	Hybrid	246	66	246	26.83%
QI	'Ohana	IMA	Immunizations for Adolescents	Meningococcal	Hybrid	246	135	246	54.88%
QI	'Ohana	IMA	Immunizations for Adolescents	Tdap	Hybrid	246	140	246	56.91%
QI	UHCCP	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Hybrid	326	178	326	54.60%
QI	UHCCP	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Hybrid	326	85	326	26.07%
QI	UHCCP	IMA	Immunizations for Adolescents	HPV	Hybrid	326	95	326	29.14%
QI	UHCCP	IMA	Immunizations for Adolescents	Meningococcal	Hybrid	326	193	326	59.20%
QI	UHCCP	IMA	Immunizations for Adolescents	Tdap	Hybrid	326	193	326	59.20%
QI	Statewide	IMA	Immunizations for Adolescents	Combination 1 (Meningococcal, Tdap)	Mixed	6,487	—	—	66.17%
QI	Statewide	IMA	Immunizations for Adolescents	Combination 2 (Meningococcal, Tdap, HPV)	Mixed	6,487	—	—	30.86%
QI	Statewide	IMA	Immunizations for Adolescents	HPV	Mixed	6,487	—	—	34.15%
QI	Statewide	IMA	Immunizations for Adolescents	Meningococcal	Mixed	6,487	—	—	68.37%
QI	Statewide	IMA	Immunizations for Adolescents	Tdap	Mixed	6,487	—	—	72.94%
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	121	321	121	2.65
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	1,265	3,382	1265	2.67
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	3	10	3	3.33
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	1,389	3,713	1389	2.67
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	178,276	321	178276	1.80
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	224,664	3,382	224664	15.05
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	122,968	10	122968	0.08
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	525,908	3,713	525908	7.06
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	178,276	121	178276	0.68
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	224,664	1,265	224664	5.63
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	122,968	3	122968	0.02
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	525,908	1,389	525908	2.64
QI	AlohaCare	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	118	464	118	3.93
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	98	428	98	4.37
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	130	421	130	3.24
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	634	2,904	634	4.58
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	1,096	5,866	1096	5.35
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	261	2,121	261	8.13
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	104	1,025	104	9.86
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	75	455	75	6.07
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	2,516	13,684	2516	5.44
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	18,676	464	18676	24.84
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	178,276	428	178276	2.40
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	173,752	421	173752	2.42
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	224,664	2,904	224664	12.93
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	122,968	5,866	122968	47.70
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	24,608	2,121	24608	86.19
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	9,731	1,025	9731	105.33
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	4,362	455	4362	104.31
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	757,037	13,684	757037	18.08
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	18,676	118	18676	6.32
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	178,276	98	178276	0.55
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	173,752	130	173752	0.75
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	224,664	634	224664	2.82

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	122,968	1,096	122968	8.91
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	24,608	261	24608	10.61
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	9,731	104	9731	10.69
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	4,362	75	4362	17.19
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	757,037	2,516	757037	3.32
QI	AlohaCare	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	160	956	160	5.98
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	286	1,305	286	4.56
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	195	1,080	195	5.54
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	2,274	9,768	2274	4.30
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	1,662	11,774	1662	7.08
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	370	3,399	370	9.19
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	174	1,697	174	9.75
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	87	543	87	6.24
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	5,208	30,522	5208	5.86
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	18,676	956	18676	51.19
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	178,276	1,305	178276	7.32
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	173,752	1,080	173752	6.22
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	224,664	9,768	224664	43.48
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	122,968	11,774	122968	95.75
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	24,608	3,399	24608	138.13
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	9,731	1,697	9731	174.39
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	4,362	543	4362	124.48
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	757,037	30,522	757037	40.32
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	18,676	160	18676	8.57
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	178,276	286	178276	1.60
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	173,752	195	173752	1.12
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	224,664	2,274	224664	10.12
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	122,968	1,662	122968	13.52
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	24,608	370	24608	15.04
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	9,731	174	9731	17.88
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	4,362	87	4362	19.94
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	757,037	5,208	757037	6.88
QI	AlohaCare	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	42	492	42	11.71
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	67	556	67	8.30
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	65	659	65	10.14
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	375	3,482	375	9.29
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	563	5,898	563	10.48
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	109	1,278	109	11.72
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	70	672	70	9.60
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	12	88	12	7.33
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	1,303	13,125	1303	10.07
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	18,676	492	18676	26.34
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	178,276	556	178276	3.12
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	173,752	659	173752	3.79
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	224,664	3,482	224664	15.50
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	122,968	5,898	122968	47.96
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	24,608	1,278	24608	51.93
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	9,731	672	9731	69.06

HI MY 2020 Performance Measure Rates
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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	4,362	88	4362	20.17
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	757,037	13,125	757037	17.34
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	18,676	42	18676	2.25
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	178,276	67	178276	0.38
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	173,752	65	173752	0.37
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	224,664	375	224664	1.67
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	122,968	563	122968	4.58
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	24,608	109	24608	4.43
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	9,731	70	9731	7.19
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	4,362	12	4362	2.75
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	757,037	1,303	757037	1.72
QI	AlohaCare	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	205	556	205	2.71
QI	HSMA	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	3,016	7,429	3016	2.46
QI	HSMA	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	6	19	6	3.17
QI	HSMA	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	3,227	8,004	3227	2.48
QI	HSMA	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	457,226	556	457226	1.22
QI	HSMA	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	569,323	7,429	569323	13.05
QI	HSMA	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	312,496	19	312496	0.06
QI	HSMA	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	1,339,045	8,004	1339045	5.98
QI	HSMA	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	457,226	205	457226	0.45
QI	HSMA	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	569,323	3,016	569323	5.30
QI	HSMA	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	312,496	6	312496	0.02
QI	HSMA	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	1,339,045	3,227	1339045	2.41
QI	HSMA	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	222	1,064	222	4.79
QI	HSMA	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	230	811	230	3.53
QI	HSMA	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	309	1,068	309	3.46
QI	HSMA	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	1,093	4,644	1093	4.25
QI	HSMA	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	1,984	9,903	1984	4.99
QI	HSMA	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	254	1,483	254	5.84
QI	HSMA	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	71	663	71	9.34
QI	HSMA	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	53	251	53	4.74
QI	HSMA	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	4,216	19,887	4216	4.72
QI	HSMA	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	49,134	1,064	49134	21.66
QI	HSMA	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	457,226	811	457226	1.77
QI	HSMA	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	465,319	1,068	465319	2.30
QI	HSMA	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	569,323	4,644	569323	8.16
QI	HSMA	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	312,496	9,903	312496	31.69
QI	HSMA	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	37,477	1,483	37477	39.57
QI	HSMA	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	8,221	663	8221	80.65
QI	HSMA	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	4,142	251	4142	60.60
QI	HSMA	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	1,903,338	19,887	1903338	10.45
QI	HSMA	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	49,134	222	49134	4.52
QI	HSMA	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	457,226	230	457226	0.50
QI	HSMA	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	465,319	309	465319	0.66
QI	HSMA	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	569,323	1,093	569323	1.92
QI	HSMA	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	312,496	1,984	312496	6.35

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	37,477	254	37477	6.78
QI	HSMA	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	8,221	71	8221	8.64
QI	HSMA	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	4,142	53	4142	12.80
QI	HSMA	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	1,903,338	4,216	1903338	2.22
QI	HSMA	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	273	1,550	273	5.68
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	529	1,921	529	3.63
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	416	2,019	416	4.85
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	4,656	15,496	4656	3.33
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	2,765	15,266	2765	5.52
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	380	2,667	380	7.02
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	99	868	99	8.77
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	67	338	67	5.04
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	9,185	40,125	9185	4.37
QI	HSMA	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	49,134	1,550	49134	31.55
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	457,226	1,921	457226	4.20
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	465,319	2,019	465319	4.34
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	569,323	15,496	569323	27.22
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	312,496	15,266	312496	48.85
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	37,477	2,667	37477	71.16
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	8,221	868	8221	105.58
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	4,142	338	4142	81.60
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	1,903,338	40,125	1903338	21.08
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	49,134	273	49134	5.56
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	457,226	529	457226	1.16
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	465,319	416	465319	0.89
QI	HSMA	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	569,323	4,656	569323	8.18
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	312,496	2,765	312496	8.85
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	37,477	380	37477	10.14
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	8,221	99	8221	12.04
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	4,142	67	4142	16.18
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	1,903,338	9,185	1903338	4.83
QI	HSMA	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	51	486	51	9.53
QI	HSMA	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	94	554	94	5.89
QI	HSMA	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	107	951	107	8.89
QI	HSMA	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	547	3,423	547	6.26
QI	HSMA	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	775	5,344	775	6.90
QI	HSMA	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	126	1,184	126	9.40
QI	HSMA	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	28	205	28	7.32
QI	HSMA	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	14	87	14	6.21
QI	HSMA	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	1,742	12,234	1742	7.02
QI	HSMA	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	49,134	486	49134	9.89
QI	HSMA	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	457,226	554	457226	1.21
QI	HSMA	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	465,319	951	465319	2.04
QI	HSMA	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	569,323	3,423	569323	6.01
QI	HSMA	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	312,496	5,344	312496	17.10
QI	HSMA	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	37,477	1,184	37477	31.59
QI	HSMA	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	8,221	205	8221	24.94
QI	HSMA	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	4,142	87	4142	21.00

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	1,903,338	12,234	1903338	6.43
QI	HSMA	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA
QI	HSMA	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	49,134	51	49134	1.04
QI	HSMA	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	457,226	94	457226	0.21
QI	HSMA	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	465,319	107	465319	0.23
QI	HSMA	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	569,323	547	569323	0.96
QI	HSMA	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	312,496	775	312496	2.48
QI	HSMA	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	37,477	126	37477	3.36
QI	HSMA	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	8,221	28	8221	3.41
QI	HSMA	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	4,142	14	4142	3.38
QI	HSMA	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	1,903,338	1,742	1903338	0.92
QI	HSMA	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	28	73	28	2.61
QI	KFHP	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	489	1,288	489	2.63
QI	KFHP	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	517	1,361	517	2.63
QI	KFHP	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	86,977	73	86977	0.84
QI	KFHP	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	85,476	1,288	85476	15.07
QI	KFHP	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	50,650	0	50650	0.00
QI	KFHP	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	223,103	1,361	223103	6.10
QI	KFHP	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	86,977	28	86977	0.32
QI	KFHP	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	85,476	489	85476	5.72
QI	KFHP	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	50,650	0	50650	0.00
QI	KFHP	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	223,103	517	223103	2.32
QI	KFHP	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	61	271	61	4.44
QI	KFHP	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	53	243	53	4.58
QI	KFHP	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	78	220	78	2.82
QI	KFHP	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	212	1,106	212	5.22
QI	KFHP	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	349	1,644	349	4.71
QI	KFHP	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	56	238	56	4.25
QI	KFHP	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	34	194	34	5.71
QI	KFHP	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	19	124	19	6.53
QI	KFHP	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	862	4,040	862	4.69
QI	KFHP	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	10,078	271	10078	26.89
QI	KFHP	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	86,977	243	86977	2.79
QI	KFHP	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	89,412	220	89412	2.46
QI	KFHP	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	85,476	1,106	85476	12.94
QI	KFHP	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	50,650	1,644	50650	32.46
QI	KFHP	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	7,288	238	7288	32.66
QI	KFHP	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	2,023	194	2023	95.90
QI	KFHP	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	1,348	124	1348	91.99
QI	KFHP	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	333,252	4,040	333252	12.12
QI	KFHP	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	10,078	61	10078	6.05
QI	KFHP	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	86,977	53	86977	0.61
QI	KFHP	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	89,412	78	89412	0.87
QI	KFHP	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	85,476	212	85476	2.48
QI	KFHP	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	50,650	349	50650	6.89
QI	KFHP	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	7,288	56	7288	7.68

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	2,023	34	2023	16.81
QI	KFHP	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	1,348	19	1348	14.09
QI	KFHP	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	333,252	862	333252	2.59
QI	KFHP	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	74	575	74	7.77
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	117	654	117	5.59
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	104	353	104	3.39
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	800	3,083	800	3.85
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	523	2,996	523	5.73
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	86	683	86	7.94
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	49	388	49	7.92
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	20	140	20	7.00
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	1,773	8,872	1773	5.00
QI	KFHP	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	10,078	575	10078	57.05
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	86,977	654	86977	7.52
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	89,412	353	89412	3.95
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	85,476	3,083	85476	36.07
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	50,650	2,996	50650	59.15
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	7,288	683	7288	93.72
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	2,023	388	2023	191.79
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	1,348	140	1348	103.86
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	333,252	8,872	333252	26.62
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	10,078	74	10078	7.34
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	86,977	117	86977	1.35
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	89,412	104	89412	1.16
QI	KFHP	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	85,476	800	85476	9.36
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	50,650	523	50650	10.33
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	7,288	86	7288	11.80
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	2,023	49	2023	24.22
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	1,348	20	1348	14.84
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	333,252	1,773	333252	5.32
QI	KFHP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	13	304	13	23.38
QI	KFHP	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	36	338	36	9.39
QI	KFHP	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	26	133	26	5.12
QI	KFHP	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	99	689	99	6.96
QI	KFHP	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	174	1,352	174	7.77
QI	KFHP	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	30	445	30	14.83
QI	KFHP	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	15	194	15	12.93
QI	KFHP	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	1	16	1	16.00
QI	KFHP	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	394	3,471	394	8.81
QI	KFHP	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	10,078	304	10078	30.16
QI	KFHP	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	86,977	338	86977	3.89
QI	KFHP	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	89,412	133	89412	1.49
QI	KFHP	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	85,476	689	85476	8.06
QI	KFHP	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	50,650	1,352	50650	26.69
QI	KFHP	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	7,288	445	7288	61.06
QI	KFHP	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	2,023	194	2023	95.90
QI	KFHP	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	1,348	16	1348	11.87
QI	KFHP	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	333,252	3,471	333252	10.42

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA
QI	KFHP	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	10,078	13	10078	1.29
QI	KFHP	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	86,977	36	86977	0.41
QI	KFHP	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	89,412	26	89412	0.29
QI	KFHP	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	85,476	99	85476	1.16
QI	KFHP	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	50,650	174	50650	3.44
QI	KFHP	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	7,288	30	7288	4.12
QI	KFHP	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	2,023	15	2023	7.41
QI	KFHP	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	1,348	1	1348	0.74
QI	KFHP	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	333,252	394	333252	1.18
QI	KFHP	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	32	77	32	2.41
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	472	1,349	472	2.86
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	2	3	2	1.50
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	506	1,429	506	2.82
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	38,844	77	38844	1.98
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	109,765	1,349	109765	12.29
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	92,614	3	92614	0.03
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	241,223	1,429	241223	5.92
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	38,844	32	38844	0.82
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	109,765	472	109765	4.30
QI	'Ohana	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	92,614	2	92614	0.02
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	241,223	506	241223	2.10
QI	'Ohana	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	39	153	39	3.92
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	61	299	61	4.90
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	59	201	59	3.41
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	512	2,737	512	5.35
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	1,202	45,193	1202	37.60
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	386	3,749	386	9.71
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	257	1,975	257	7.68
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	141	3,554	141	25.21
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	2,657	57,861	2657	21.78
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	7,589	153	7589	20.16
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	38,844	299	38844	7.70
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	47,093	201	47093	4.27
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	109,765	2,737	109765	24.94
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	92,614	45,193	92614	487.97
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	23,470	3,749	23470	159.74
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	14,751	1,975	14751	133.89
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	7,456	3,554	7456	476.66
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	341,582	57,861	341582	169.39
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	7,589	39	7589	5.14
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	38,844	61	38844	1.57
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	47,093	59	47093	1.25
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	109,765	512	109765	4.66
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	92,614	1,202	92614	12.98
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	23,470	386	23470	16.45
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	14,751	257	14751	17.42

HI MY 2020 Performance Measure Rates
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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	7,456	141	7456	18.91
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	341,582	2,657	341582	7.78
QI	'Ohana	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	53	330	53	6.23
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	133	911	133	6.85
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	85	475	85	5.59
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	1,195	6,926	1195	5.80
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	1,657	54,487	1657	32.88
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	532	5,423	532	10.19
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	319	3,047	319	9.55
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	167	3,815	167	22.84
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	4,141	75,414	4141	18.21
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	7,589	330	7589	43.48
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	38,844	911	38844	23.45
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	47,093	475	47093	10.09
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	109,765	6,926	109765	63.10
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	92,614	54,487	92614	588.32
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	23,470	5,423	23470	231.06
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	14,751	3,047	14751	206.56
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	7,456	3,815	7456	511.67
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	341,582	75,414	341582	220.78
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	7,589	53	7589	6.98
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	38,844	133	38844	3.42
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	47,093	85	47093	1.80
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	109,765	1,195	109765	10.89
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	92,614	1,657	92614	17.89
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	23,470	532	23470	22.67
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	14,751	319	14751	21.63
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	7,456	167	7456	22.40
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	341,582	4,141	341582	12.12
QI	'Ohana	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	14	177	14	12.64
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	40	535	40	13.38
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	26	274	26	10.54
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	211	2,840	211	13.46
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	453	9,291	453	20.51
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	146	1,674	146	11.47
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	62	1,072	62	17.29
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	26	261	26	10.04
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	978	16,124	978	16.49
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	'Ohana	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	7,589	177	7589	23.32
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	38,844	535	38844	13.77
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	47,093	274	47093	5.82
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	109,765	2,840	109765	25.87
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	92,614	9,291	92614	100.32
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	23,470	1,674	23470	71.33
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	14,751	1,072	14751	72.67
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	7,456	261	7456	35.01
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	341,582	16,124	341582	47.20
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA

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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	7,589	14	7589	1.84
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	38,844	40	38844	1.03
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	47,093	26	47093	0.55
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	109,765	211	109765	1.92
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	92,614	453	92614	4.89
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	23,470	146	23470	6.22
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	14,751	62	14751	4.20
QI	'Ohana	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	7,456	26	7456	3.49
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	341,582	978	341582	2.86
QI	'Ohana	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	51	152	51	2.98
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	684	1,874	684	2.74
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	4	39	4	9.75
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	739	2,065	739	2.79
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	54,407	152	54407	2.79
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	162,093	1,874	162093	11.56
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	125,611	39	125611	0.31
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	342,111	2,065	342111	6.04
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	54,407	51	54407	0.94
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	162,093	684	162093	4.22
QI	UHCCP	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	125,611	4	125611	0.03
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	342,111	739	342111	2.16
QI	UHCCP	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	67	291	67	4.34
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	27	118	27	4.37
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	70	266	70	3.80
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	569	2,731	569	4.80
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	1,337	7,174	1337	5.37
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	669	3,675	669	5.49
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	415	2,326	415	5.60
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	287	1,557	287	5.43
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	3,441	18,138	3441	5.27
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	10,834	291	10834	26.86
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	54,407	118	54407	2.17
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	63,800	266	63800	4.17
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	162,093	2,731	162093	16.85
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	125,611	7,174	125611	57.11
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	60,372	3,675	60372	60.87
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	41,922	2,326	41922	55.48
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	18,985	1,557	18985	82.01
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	538,024	18,138	538024	33.71
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	10,834	67	10834	6.18
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	54,407	27	54407	0.50
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	63,800	70	63800	1.10
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	162,093	569	162093	3.51
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	125,611	1,337	125611	10.64
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	60,372	669	60372	11.08
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	41,922	415	41922	9.90
QI	UHCCP	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	18,985	287	18985	15.12

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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	538,024	3,441	538024	6.40
QI	UHCCP	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	92	481	92	5.23
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	99	566	99	5.72
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	95	686	95	7.22
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	1,532	7,286	1532	4.76
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	2,039	15,231	2039	7.47
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	1,001	6,879	1001	6.87
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	614	4,033	614	6.57
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	366	2,253	366	6.16
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	5,838	37,415	5838	6.41
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	10,834	481	10834	44.40
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	54,407	566	54407	10.40
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	63,800	686	63800	10.75
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	162,093	7,286	162093	44.95
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	125,611	15,231	125611	121.26
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	60,372	6,879	60372	113.94
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	41,922	4,033	41922	96.20
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	18,985	2,253	18985	118.67
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	538,024	37,415	538024	69.54
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	10,834	92	10834	8.49
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	54,407	99	54407	1.82
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	63,800	95	63800	1.49
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	162,093	1,532	162093	9.45
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	125,611	2,039	125611	16.23
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	60,372	1,001	60372	16.58
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	41,922	614	41922	14.65
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	18,985	366	18985	19.28
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	538,024	5,838	538024	10.85
QI	UHCCP	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	25	190	25	7.60
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	21	296	21	14.10
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	25	420	25	16.80
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	279	2,681	279	9.61
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	698	8,018	698	11.49
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	332	3,204	332	9.65
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	199	1,707	199	8.58
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	79	696	79	8.81
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	1,658	17,212	1658	10.38
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	10,834	190	10834	17.54
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	54,407	296	54407	5.44
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	63,800	420	63800	6.58
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	162,093	2,681	162093	16.54
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	125,611	8,018	125611	63.83
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	60,372	3,204	60372	53.07
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	41,922	1,707	41922	40.72
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	18,985	696	18985	36.66
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	538,024	17,212	538024	31.99
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA
QI	UHCCP	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	10,834	25	10834	2.31

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	54,407	21	54407	0.39
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	63,800	25	63800	0.39
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	162,093	279	162093	1.72
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	125,611	698	125611	5.56
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	60,372	332	60372	5.50
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	41,922	199	41922	4.75
QI	UHCCP	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	18,985	79	18985	4.16
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	538,024	1,658	538024	3.08
QI	UHCCP	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Maternity 10-19 ALOS	Admin	437	1,179	437	2.70
QI	Statewide	IPUA	Inpatient Utilization	Maternity 20-44 ALOS	Admin	5,926	15,322	5926	2.59
QI	Statewide	IPUA	Inpatient Utilization	Maternity 45-64 ALOS	Admin	15	71	15	4.73
QI	Statewide	IPUA	Inpatient Utilization	Maternity Tot ALOS	Admin	6,378	16,572	6378	2.60
QI	Statewide	IPUA	Inpatient Utilization	Maternity Unk ALOS	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Maternity 10-19 Days/1000 MM	Admin	815,730	1,179	815730	1.45
QI	Statewide	IPUA	Inpatient Utilization	Maternity 20-44 Days/1000 MM	Admin	1,151,321	15,322	1151321	13.31
QI	Statewide	IPUA	Inpatient Utilization	Maternity 45-64 Days/1000 MM	Admin	704,339	71	704339	0.10
QI	Statewide	IPUA	Inpatient Utilization	Maternity Tot Days/1000 MM	Admin	2,671,390	16,572	2671390	6.20
QI	Statewide	IPUA	Inpatient Utilization	Maternity Unk Days/1000 MM	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Maternity 10-19 Ds/1000 MM	Admin	815,730	437	815730	0.54
QI	Statewide	IPUA	Inpatient Utilization	Maternity 20-44 Ds/1000	Admin	1,151,321	5,926	1151321	5.15
QI	Statewide	IPUA	Inpatient Utilization	Maternity 45-64 Ds/1000	Admin	704,339	15	704339	0.02
QI	Statewide	IPUA	Inpatient Utilization	Maternity Tot Ds/1000	Admin	2,671,390	6,378	2671390	2.39
QI	Statewide	IPUA	Inpatient Utilization	Maternity Unk Ds/1000	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Medicine <1 ALOS	Admin	507	2,243	507	4.42
QI	Statewide	IPUA	Inpatient Utilization	Medicine 10-19 ALOS	Admin	469	1,899	469	4.05
QI	Statewide	IPUA	Inpatient Utilization	Medicine 1-9 ALOS	Admin	646	2,176	646	3.37
QI	Statewide	IPUA	Inpatient Utilization	Medicine 20-44 ALOS	Admin	3,020	14,122	3020	4.68
QI	Statewide	IPUA	Inpatient Utilization	Medicine 45-64 ALOS	Admin	5,968	69,780	5968	11.69
QI	Statewide	IPUA	Inpatient Utilization	Medicine 65-74 ALOS	Admin	1,626	11,266	1626	6.93
QI	Statewide	IPUA	Inpatient Utilization	Medicine 75-84 ALOS	Admin	881	6,183	881	7.02
QI	Statewide	IPUA	Inpatient Utilization	Medicine 85+ ALOS	Admin	575	5,941	575	10.33
QI	Statewide	IPUA	Inpatient Utilization	Medicine Tot ALOS	Admin	13,692	113,610	13692	8.30
QI	Statewide	IPUA	Inpatient Utilization	Medicine Unk ALOS	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Medicine <1 Days/1000 MM	Admin	96,311	2,243	96311	23.29
QI	Statewide	IPUA	Inpatient Utilization	Medicine 10-19 Days/1000 MM	Admin	815,730	1,899	815730	2.33
QI	Statewide	IPUA	Inpatient Utilization	Medicine 1-9 Days/1000 MM	Admin	839,376	2,176	839376	2.59
QI	Statewide	IPUA	Inpatient Utilization	Medicine 20-44 Days/1000 MM	Admin	1,151,321	14,122	1151321	12.27
QI	Statewide	IPUA	Inpatient Utilization	Medicine 45-64 Days/1000 MM	Admin	704,339	69,780	704339	99.07
QI	Statewide	IPUA	Inpatient Utilization	Medicine 65-74 Days/1000 MM	Admin	153,215	11,266	153215	73.53
QI	Statewide	IPUA	Inpatient Utilization	Medicine 75-84 Days/1000 MM	Admin	76,648	6,183	76648	80.67
QI	Statewide	IPUA	Inpatient Utilization	Medicine 85+ Days/1000 MM	Admin	36,293	5,941	36293	163.70
QI	Statewide	IPUA	Inpatient Utilization	Medicine Tot Days/1000 MM	Admin	3,873,233	113,610	3873233	29.33
QI	Statewide	IPUA	Inpatient Utilization	Medicine Days/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Medicine <1 Ds/1000	Admin	96,311	507	96311	5.26
QI	Statewide	IPUA	Inpatient Utilization	Medicine 10-19 Ds/1000 MM	Admin	815,730	469	815730	0.57
QI	Statewide	IPUA	Inpatient Utilization	Medicine 1-9 Ds/1000 MM	Admin	839,376	646	839376	0.77
QI	Statewide	IPUA	Inpatient Utilization	Medicine 20-44 Ds/1000	Admin	1,151,321	3,020	1151321	2.62
QI	Statewide	IPUA	Inpatient Utilization	Medicine 45-64 Ds/1000	Admin	704,339	5,968	704339	8.47
QI	Statewide	IPUA	Inpatient Utilization	Medicine 65-74 Ds/1000	Admin	153,215	1,626	153215	10.61
QI	Statewide	IPUA	Inpatient Utilization	Medicine 75-84 Ds/1000	Admin	76,648	881	76648	11.49
QI	Statewide	IPUA	Inpatient Utilization	Medicine 85+ Ds/1000	Admin	36,293	575	36293	15.84
QI	Statewide	IPUA	Inpatient Utilization	Medicine Tot Ds/1000	Admin	3,873,233	13,692	3873233	3.54

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	IPUA	Inpatient Utilization	Medicine Ds/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS <1	Admin	652	3,892	652	5.97
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 10-19	Admin	1,164	5,357	1164	4.60
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 1-9	Admin	895	4,613	895	5.15
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 20-44	Admin	10,457	42,559	10457	4.07
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 45-64	Admin	8,646	99,754	8646	11.54
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 65-74	Admin	2,369	19,051	2369	8.04
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 75-84	Admin	1,255	10,033	1255	7.99
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS 85+	Admin	707	7,089	707	10.03
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS Tot	Admin	26,145	192,348	26145	7.36
QI	Statewide	IPUA	Inpatient Utilization	Tot IP ALOS Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 <1	Admin	96,311	3,892	96311	40.41
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 10-19	Admin	815,730	5,357	815730	6.57
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 1-9	Admin	839,376	4,613	839376	5.50
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 20-44	Admin	1,151,321	42,559	1151321	36.97
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 45-64	Admin	704,339	99,754	704339	141.63
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 65-74	Admin	153,215	19,051	153215	124.34
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 75-84	Admin	76,648	10,033	76648	130.90
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM 85+	Admin	36,293	7,089	36293	195.33
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Tot	Admin	3,873,233	192,348	3873233	49.66
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Days/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 <1	Admin	96,311	652	96311	6.77
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 10-19	Admin	815,730	1,164	815730	1.43
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 1-9	Admin	839,376	895	839376	1.07
QI	Statewide	IPUA	Inpatient Utilization	Tot IP 20-44 Ds/1000	Admin	1,151,321	10,457	1151321	9.08
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 45-64	Admin	704,339	8,646	704339	12.28
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 65-74	Admin	153,215	2,369	153215	15.46
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 75-84	Admin	76,648	1,255	76648	16.37
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM 85+	Admin	36,293	707	36293	19.48
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Tot	Admin	3,873,233	26,145	3873233	6.75
QI	Statewide	IPUA	Inpatient Utilization	Tot IP Ds/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Surgery <1 ALOS	Admin	145	1,649	145	11.37
QI	Statewide	IPUA	Inpatient Utilization	Surgery 10-19 ALOS	Admin	258	2,279	258	8.83
QI	Statewide	IPUA	Inpatient Utilization	Surgery 1-9 ALOS	Admin	249	2,437	249	9.79
QI	Statewide	IPUA	Inpatient Utilization	Surgery 20-44 ALOS	Admin	1,511	13,115	1511	8.68
QI	Statewide	IPUA	Inpatient Utilization	Surgery 45-64 ALOS	Admin	2,663	29,903	2663	11.23
QI	Statewide	IPUA	Inpatient Utilization	Surgery 65-74 ALOS	Admin	743	7,785	743	10.48
QI	Statewide	IPUA	Inpatient Utilization	Surgery 75-84 ALOS	Admin	374	3,850	374	10.29
QI	Statewide	IPUA	Inpatient Utilization	Surgery 85+ ALOS	Admin	132	1,148	132	8.70
QI	Statewide	IPUA	Inpatient Utilization	Surgery Tot ALOS	Admin	6,075	62,166	6075	10.23
QI	Statewide	IPUA	Inpatient Utilization	Surgery Unk ALOS	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Surgery <1 Days/1000 MM	Admin	96,311	1,649	96311	17.12
QI	Statewide	IPUA	Inpatient Utilization	Surgery 10-19 Days/1000 MM	Admin	815,730	2,279	815730	2.79
QI	Statewide	IPUA	Inpatient Utilization	Surgery 1-9 Days/1000 MM	Admin	839,376	2,437	839376	2.90
QI	Statewide	IPUA	Inpatient Utilization	Surgery 20-44 Days/1000 MM	Admin	1,151,321	13,115	1151321	11.39
QI	Statewide	IPUA	Inpatient Utilization	Surgery 45-64 Days/1000 MM	Admin	704,339	29,903	704339	42.46
QI	Statewide	IPUA	Inpatient Utilization	Surgery 65-74 Days/1000 MM	Admin	153,215	7,785	153215	50.81
QI	Statewide	IPUA	Inpatient Utilization	Surgery 75-84 Days/1000 MM	Admin	76,648	3,850	76648	50.23
QI	Statewide	IPUA	Inpatient Utilization	Surgery 85+ Days/1000 MM	Admin	36,293	1,148	36293	31.63
QI	Statewide	IPUA	Inpatient Utilization	Surgery Tot Days/1000 MM	Admin	3,873,233	62,166	3873233	16.05
QI	Statewide	IPUA	Inpatient Utilization	Surgery Days/1000 MM Unk	Admin	0	0	0	NA
QI	Statewide	IPUA	Inpatient Utilization	Surgery <1 Ds/1000	Admin	96,311	145	96311	1.51
QI	Statewide	IPUA	Inpatient Utilization	Surgery 10-19 Ds/1000 MM	Admin	815,730	258	815730	0.32

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	IPUA	Inpatient Utilization	Surgery 1-9 Ds/1000 MM	Admin	839,376	249	839376	0.30
QI	Statewide	IPUA	Inpatient Utilization	Surgery 20-44 Ds/1000	Admin	1,151,321	1,511	1151321	1.31
QI	Statewide	IPUA	Inpatient Utilization	Surgery 45-64 Ds/1000	Admin	704,339	2,663	704339	3.78
QI	Statewide	IPUA	Inpatient Utilization	Surgery 65-74 Ds/1000	Admin	153,215	743	153215	4.85
QI	Statewide	IPUA	Inpatient Utilization	Surgery 75-84 Ds/1000	Admin	76,648	374	76648	4.88
QI	Statewide	IPUA	Inpatient Utilization	Surgery 85+ Ds/1000	Admin	36,293	132	36293	3.64
QI	Statewide	IPUA	Inpatient Utilization	Surgery Tot Ds/1000	Admin	3,873,233	6,075	3873233	1.57
QI	Statewide	IPUA	Inpatient Utilization	Surgery Ds/1000 MM Unk	Admin	0	0	0	NA
QI	AlohaCare	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	2,573	2,243	2573	87.17%
QI	AlohaCare	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	1,197	1,061	1197	88.64%
QI	AlohaCare	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	3,770	3,304	3770	87.64%
QI	HSMA	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	6,024	5,168	6024	85.79%
QI	HSMA	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	2,935	2,515	2935	85.69%
QI	HSMA	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	8,959	7,683	8959	85.76%
QI	KFHP	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	1,338	1,251	1338	93.50%
QI	KFHP	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	600	560	600	93.33%
QI	KFHP	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	1,938	1,811	1938	93.45%
QI	'Ohana	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	2,879	2,660	2879	92.39%
QI	'Ohana	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	1,295	1,198	1295	92.51%
QI	'Ohana	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	4,174	3,858	4174	92.43%
QI	UHCCP	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	6,007	5,569	6007	92.71%
QI	UHCCP	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	2,684	2,497	2684	93.03%
QI	UHCCP	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	8,691	8,066	8691	92.81%
QI	Statewide	MPM	Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs	Admin	18,821	16,891	18821	89.75%
QI	Statewide	MPM	Annual Monitoring for Patients on Persistent Medications	Diuretics	Admin	8,711	7,831	8711	89.90%
QI	Statewide	MPM	Annual Monitoring for Patients on Persistent Medications	Total	Admin	27,532	24,722	27532	89.79%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	122,189	257	122189	2.52%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	42,882	297	42882	8.31%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	194,147	2,015	194147	12.45%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	22,772	91	22772	4.80%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	381,990	2,660	381990	8.36%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	131,610	327	131610	2.98%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	45,945	241	45945	6.29%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	181,563	1,617	181563	10.69%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	15,929	61	15929	4.60%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	375,047	2,246	375047	7.19%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	253,799	584	253799	2.76%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	88,827	538	88827	7.27%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	375,710	3,632	375710	11.60%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	38,701	152	38701	4.71%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	757,037	4,906	757037	7.78%
QI	AlohaCare	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	122,189	258	122189	2.53%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	42,882	302	42882	8.45%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	194,147	2,093	194147	12.94%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	22,772	136	22772	7.17%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	381,990	2,789	381990	8.76%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	131,610	332	131610	3.03%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	45,945	248	45945	6.48%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	181,563	1,705	181563	11.27%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	15,929	82	15929	6.18%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	375,047	2,367	375047	7.57%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	253,799	590	253799	2.79%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	88,827	550	88827	7.43%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	375,710	3,798	375710	12.13%
QI	AlohaCare	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	38,701	218	38701	6.76%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	757,037	5,156	757037	8.17%
QI	AlohaCare	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	122,189	0	122189	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	42,882	0	42882	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	194,147	3	194147	0.02%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	22,772	0	22772	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	381,990	3	381990	0.01%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	131,610	0	131610	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	45,945	3	45945	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	181,563	9	181563	0.06%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	15,929	0	15929	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	375,047	12	375047	0.04%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	253,799	0	253799	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	88,827	3	88827	0.04%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	375,710	12	375710	0.04%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	38,701	0	38701	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	757,037	15	757037	0.02%
QI	AlohaCare	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	122,189	2	122189	0.02%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	42,882	1	42882	0.03%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	194,147	15	194147	0.09%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	22,772	0	22772	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	381,990	18	381990	0.06%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	131,610	0	131610	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	45,945	4	45945	0.10%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	181,563	33	181563	0.22%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	15,929	1	15929	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	375,047	38	375047	0.12%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	253,799	2	253799	0.01%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	88,827	5	88827	0.07%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	375,710	48	375710	0.15%
QI	AlohaCare	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	38,701	1	38701	0.03%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	757,037	56	757037	0.09%
QI	AlohaCare	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	122,189	8	122189	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	42,882	26	42882	0.73%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	194,147	118	194147	0.73%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	22,772	46	22772	2.42%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	381,990	198	381990	0.62%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	131,610	8	131610	0.07%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	45,945	18	45945	0.47%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	181,563	144	181563	0.95%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	15,929	24	15929	1.81%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	375,047	194	375047	0.62%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	253,799	16	253799	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	88,827	44	88827	0.59%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	375,710	262	375710	0.84%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	38,701	70	38701	2.17%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	757,037	392	757037	0.62%
QI	AlohaCare	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	122,189	4	122189	0.04%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	42,882	9	42882	0.25%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	194,147	43	194147	0.27%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	22,772	3	22772	0.16%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	381,990	59	381990	0.19%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	131,610	9	131610	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	45,945	1	45945	0.03%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	181,563	15	181563	0.10%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	15,929	0	15929	0.00%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	375,047	25	375047	0.08%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	253,799	13	253799	0.06%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	88,827	10	88827	0.14%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	375,710	58	375710	0.19%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	38,701	3	38701	0.09%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	757,037	84	757037	0.13%
QI	AlohaCare	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	322,908	1,413	322908	5.25%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	109,548	1,268	109548	13.89%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	543,440	8,003	543440	17.67%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	29,165	146	29165	6.01%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	1,005,061	10,830	1005061	12.93%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	346,839	1,774	346839	6.14%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	119,002	1,107	119002	11.16%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	402,592	4,571	402592	13.62%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	20,170	87	20170	5.18%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	888,603	7,539	888603	10.18%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	669,747	3,187	669747	5.71%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	228,550	2,375	228550	12.47%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	946,032	12,574	946032	15.95%
QI	HSMA	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	49,335	233	49335	5.67%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	1,893,664	18,369	1893664	11.64%
QI	HSMA	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	322,908	1,417	322908	5.27%
QI	HSMA	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	109,548	1,296	109548	14.20%
QI	HSMA	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	543,440	8,128	543440	17.95%
QI	HSMA	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	29,165	157	29165	6.46%
QI	HSMA	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	1,005,061	10,998	1005061	13.13%
QI	HSMA	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	346,839	1,792	346839	6.20%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	119,002	1,127	119002	11.36%
QI	HSMA	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	402,592	4,704	402592	14.02%
QI	HSMA	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	20,170	97	20170	5.77%
QI	HSMA	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	888,603	7,720	888603	10.43%
QI	HSMA	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	669,747	3,209	669747	5.75%
QI	HSMA	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	228,550	2,423	228550	12.72%
QI	HSMA	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	946,032	12,832	946032	16.28%
QI	HSMA	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	49,335	254	49335	6.18%
QI	HSMA	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	1,893,664	18,718	1893664	11.86%
QI	HSMA	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	322,908	0	322908	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	109,548	4	109548	0.04%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	543,440	39	543440	0.09%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	29,165	0	29165	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	1,005,061	43	1005061	0.05%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	346,839	0	346839	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	119,002	1	119002	0.01%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	402,592	76	402592	0.23%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	20,170	0	20170	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	888,603	77	888603	0.10%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	669,747	0	669747	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	228,550	5	228550	0.03%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	946,032	115	946032	0.15%
QI	HSMA	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	49,335	0	49335	0.00%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	1,893,664	120	1893664	0.08%
QI	HSMA	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	322,908	7	322908	0.03%
QI	HSMA	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	109,548	32	109548	0.35%
QI	HSMA	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	543,440	121	543440	0.27%
QI	HSMA	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	29,165	2	29165	0.08%
QI	HSMA	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	1,005,061	162	1005061	0.19%
QI	HSMA	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	346,839	8	346839	0.03%
QI	HSMA	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	119,002	22	119002	0.22%
QI	HSMA	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	402,592	131	402592	0.39%
QI	HSMA	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	20,170	3	20170	0.18%
QI	HSMA	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	888,603	164	888603	0.22%
QI	HSMA	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	669,747	15	669747	0.03%
QI	HSMA	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	228,550	54	228550	0.28%
QI	HSMA	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	946,032	252	946032	0.32%
QI	HSMA	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	49,335	5	49335	0.12%
QI	HSMA	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	1,893,664	326	1893664	0.21%
QI	HSMA	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	322,908	21	322908	0.08%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	109,548	109	109548	1.19%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	543,440	207	543440	0.46%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	29,165	11	29165	0.45%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	1,005,061	348	1005061	0.42%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	346,839	20	346839	0.07%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	119,002	56	119002	0.56%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	402,592	242	402592	0.72%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	20,170	9	20170	0.54%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	888,603	327	888603	0.44%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	669,747	41	669747	0.07%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	228,550	165	228550	0.87%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	946,032	449	946032	0.57%
QI	HSMA	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	49,335	20	49335	0.49%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	1,893,664	675	1893664	0.43%
QI	HSMA	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	322,908	18	322908	0.07%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	109,548	61	109548	0.67%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	543,440	310	543440	0.68%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	29,165	3	29165	0.12%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	1,005,061	392	1005061	0.47%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	346,839	34	346839	0.12%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	119,002	31	119002	0.31%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	402,592	110	402592	0.33%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	20,170	1	20170	0.06%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	888,603	176	888603	0.24%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	669,747	52	669747	0.09%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	228,550	92	228550	0.48%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	946,032	420	946032	0.53%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	49,335	4	49335	0.10%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	1,893,664	568	1893664	0.36%
QI	HSMA	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	62,733	211	62733	4.04%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	20,902	232	20902	13.32%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	88,852	1,093	88852	14.76%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	6,801	31	6801	5.47%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	179,288	1,567	179288	10.49%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	67,045	430	67045	7.70%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	22,779	185	22779	9.75%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	60,282	521	60282	10.37%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	3,858	23	3858	7.15%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	153,964	1,159	153964	9.03%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	129,778	641	129778	5.93%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	43,681	417	43681	11.46%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	149,134	1,614	149134	12.99%
QI	KFHP	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	10,659	54	10659	6.08%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	333,252	2,726	333252	9.82%
QI	KFHP	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	62,733	211	62733	4.04%
QI	KFHP	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	20,902	233	20902	13.38%
QI	KFHP	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	88,852	1,103	88852	14.90%
QI	KFHP	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	6,801	40	6801	7.06%
QI	KFHP	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	179,288	1,587	179288	10.62%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	67,045	430	67045	7.70%
QI	KFHP	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	22,779	186	22779	9.80%
QI	KFHP	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	60,282	529	60282	10.53%
QI	KFHP	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	3,858	26	3858	8.09%
QI	KFHP	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	153,964	1,171	153964	9.13%
QI	KFHP	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	129,778	641	129778	5.93%
QI	KFHP	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	43,681	419	43681	11.51%
QI	KFHP	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	149,134	1,632	149134	13.13%
QI	KFHP	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	10,659	66	10659	7.43%
QI	KFHP	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	333,252	2,758	333252	9.93%
QI	KFHP	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	62,733	0	62733	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	20,902	5	20902	0.29%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	88,852	25	88852	0.34%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	6,801	0	6801	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	179,288	30	179288	0.20%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	67,045	0	67045	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	22,779	3	22779	0.16%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	60,282	10	60282	0.20%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	3,858	0	3858	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	153,964	13	153964	0.10%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	129,778	0	129778	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	43,681	8	43681	0.22%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	149,134	35	149134	0.28%
QI	KFHP	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	10,659	0	10659	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	333,252	43	333252	0.15%
QI	KFHP	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	62,733	0	62733	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	20,902	2	20902	0.11%
QI	KFHP	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	88,852	3	88852	0.04%
QI	KFHP	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	6,801	0	6801	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	179,288	5	179288	0.03%
QI	KFHP	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	67,045	0	67045	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	22,779	3	22779	0.16%
QI	KFHP	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	60,282	1	60282	0.02%
QI	KFHP	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	3,858	0	3858	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	153,964	4	153964	0.03%
QI	KFHP	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	129,778	0	129778	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	43,681	5	43681	0.14%
QI	KFHP	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	149,134	4	149134	0.03%
QI	KFHP	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	10,659	0	10659	0.00%
QI	KFHP	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	333,252	9	333252	0.03%
QI	KFHP	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	62,733	9	62733	0.17%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	20,902	25	20902	1.44%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	88,852	47	88852	0.63%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	6,801	11	6801	1.94%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	KFHP	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	179,288	92	179288	0.62%
QI	KFHP	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	67,045	2	67045	0.04%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	22,779	10	22779	0.53%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	60,282	38	60282	0.76%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	3,858	3	3858	0.93%
QI	KFHP	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	153,964	53	153964	0.41%
QI	KFHP	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	129,778	11	129778	0.10%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	43,681	35	43681	0.96%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	149,134	85	149134	0.68%
QI	KFHP	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	10,659	14	10659	1.58%
QI	KFHP	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	333,252	145	333252	0.52%
QI	KFHP	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	62,733	1	62733	0.02%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	20,902	5	20902	0.29%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	88,852	22	88852	0.30%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	6,801	0	6801	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	179,288	28	179288	0.19%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	67,045	0	67045	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	22,779	2	22779	0.11%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	60,282	11	60282	0.22%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	3,858	0	3858	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	153,964	13	153964	0.10%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	129,778	1	129778	0.01%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	43,681	7	43681	0.19%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	149,134	33	149134	0.27%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	10,659	0	10659	0.00%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	333,252	41	333252	0.15%
QI	KFHP	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	32,383	59	32383	2.19%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	9,389	73	9389	9.33%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	90,539	1,409	90539	18.67%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	28,683	151	28683	6.32%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	160,994	1,692	160994	12.61%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	34,870	92	34870	3.17%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	10,171	57	10171	6.73%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	108,465	1,481	108465	16.39%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	16,155	121	16155	8.99%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	169,661	1,751	169661	12.38%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	67,253	151	67253	2.69%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	19,560	130	19560	7.98%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	199,004	2,890	199004	17.43%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	44,838	272	44838	7.28%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	330,655	3,443	330655	1.04%
QI	'Ohana	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	32,383	59	32383	2.19%
QI	'Ohana	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	9,389	81	9389	10.35%
QI	'Ohana	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	90,539	1,455	90539	19.28%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	28,683	184	28683	7.70%
QI	'Ohana	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	160,994	1,779	160994	13.26%
QI	'Ohana	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	34,870	92	34870	3.17%
QI	'Ohana	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	10,171	57	10171	6.73%
QI	'Ohana	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	108,465	1,539	108465	17.03%
QI	'Ohana	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	16,155	130	16155	9.66%
QI	'Ohana	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	169,661	1,818	169661	12.86%
QI	'Ohana	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	67,253	151	67253	2.69%
QI	'Ohana	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	19,560	138	19560	8.47%
QI	'Ohana	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	199,004	2,994	199004	18.05%
QI	'Ohana	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	44,838	314	44838	8.40%
QI	'Ohana	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	330,655	3,597	330655	13.05%
QI	'Ohana	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	32,383	0	32383	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	9,389	3	9389	0.38%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	90,539	19	90539	0.25%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	28,683	0	28683	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	160,994	22	160994	0.16%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	34,870	0	34870	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	10,171	1	10171	0.12%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	108,465	23	108465	0.25%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	16,155	0	16155	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	169,661	24	169661	0.17%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	67,253	0	67253	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	19,560	4	19560	0.25%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	199,004	42	199004	0.25%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	44,838	0	44838	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	330,655	46	330655	0.17%
QI	'Ohana	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	32,383	0	32383	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	9,389	3	9389	0.38%
QI	'Ohana	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	90,539	11	90539	0.15%
QI	'Ohana	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	28,683	2	28683	0.08%
QI	'Ohana	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	160,994	16	160994	0.12%
QI	'Ohana	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	34,870	0	34870	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	10,171	1	10171	0.12%
QI	'Ohana	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	108,465	16	108465	0.18%
QI	'Ohana	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	16,155	1	16155	0.07%
QI	'Ohana	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	169,661	18	169661	0.13%
QI	'Ohana	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	67,253	0	67253	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	19,560	4	19560	0.25%
QI	'Ohana	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	199,004	27	199004	0.16%
QI	'Ohana	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	44,838	3	44838	0.08%
QI	'Ohana	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	330,655	34	330655	0.12%
QI	'Ohana	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	32,383	3	32383	0.11%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	9,389	15	9389	1.92%

HI MY 2020 Performance Measure Rates
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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	90,539	79	90539	1.05%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	28,683	33	28683	1.38%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	160,994	130	160994	0.97%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	34,870	—	34870	
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	10,171	6	10171	0.71%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	108,465	133	108465	1.47%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	16,155	13	16155	0.97%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	169,661	152	169661	1.08%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	67,253	3	67253	0.05%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	19,560	21	19560	1.29%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	199,004	212	199004	1.28%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	44,838	46	44838	1.23%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	330,655	282	330655	1.02%
QI	'Ohana	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	32,383	3	32383	0.11%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	9,389	7	9389	0.89%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	90,539	20	90539	0.27%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	28,683	2	28683	0.08%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	160,994	32	160994	0.24%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	34,870	1	34870	0.03%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	10,171	2	10171	0.24%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	108,465	13	108465	0.14%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	16,155	0	16155	0.00%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	169,661	16	169661	0.11%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	67,253	4	67253	0.07%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	19,560	9	19560	0.55%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	199,004	33	199004	0.20%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	44,838	2	44838	0.05%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	330,655	48	330655	0.17%
QI	'Ohana	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	44,182	82	44182	2.23%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	12,625	81	12625	7.70%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	139,342	1,920	139342	16.53%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	77,153	476	77153	7.40%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	273,302	2,559	273302	11.24%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	48,263	104	48263	2.59%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	14,068	68	14068	5.80%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	158,265	1,935	158265	14.67%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	44,126	254	44126	6.91%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	264,722	2,361	264722	10.70%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	92,445	186	92445	2.41%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	26,693	149	26693	6.70%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	297,607	3,855	297607	15.54%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	121,279	730	121279	7.22%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	538,024	4,920	538024	10.97%
QI	UHCCP	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	44,182	82	44182	2.23%

HI MY 2020 Performance Measure Rates
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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	12,625	83	12625	7.89%
QI	UHCCP	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	139,342	1,975	139342	17.01%
QI	UHCCP	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	77,153	513	77153	7.98%
QI	UHCCP	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	273,302	2,653	273302	11.65%
QI	UHCCP	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	48,263	104	48263	2.59%
QI	UHCCP	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	14,068	69	14068	5.89%
QI	UHCCP	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	158,265	2,009	158265	15.23%
QI	UHCCP	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	44,126	275	44126	7.48%
QI	UHCCP	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	264,722	2,457	264722	11.14%
QI	UHCCP	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	92,445	186	92445	2.41%
QI	UHCCP	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	26,693	152	26693	6.83%
QI	UHCCP	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	297,607	3,984	297607	16.06%
QI	UHCCP	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	121,279	788	121279	7.80%
QI	UHCCP	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	538,024	5,110	538024	11.40%
QI	UHCCP	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	44,182	0	44182	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	12,625	0	12625	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	139,342	2	139342	0.02%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	77,153	0	77153	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	273,302	2	273302	0.01%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	48,263	0	48263	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	14,068	0	14068	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	158,265	12	158265	0.09%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	44,126	0	44126	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	264,722	12	264722	0.05%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	92,445	0	92445	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	26,693	0	26693	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	297,607	14	297607	0.06%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	121,279	0	121279	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	538,024	14	538024	0.03%
QI	UHCCP	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	44,182	0	44182	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	12,625	2	12625	0.19%
QI	UHCCP	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	139,342	24	139342	0.21%
QI	UHCCP	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	77,153	2	77153	0.03%
QI	UHCCP	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	273,302	28	273302	0.12%
QI	UHCCP	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	48,263	2	48263	0.05%
QI	UHCCP	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	14,068	0	14068	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	158,265	42	158265	0.32%
QI	UHCCP	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	44,126	3	44126	0.08%
QI	UHCCP	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	264,722	47	264722	0.21%
QI	UHCCP	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	92,445	2	92445	0.03%
QI	UHCCP	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	26,693	2	26693	0.09%
QI	UHCCP	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	297,607	66	297607	0.27%
QI	UHCCP	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	121,279	5	121279	0.05%
QI	UHCCP	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	538,024	75	538024	0.17%
QI	UHCCP	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	44,182	2	44182	0.05%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	12,625	6	12625	0.57%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	139,342	116	139342	1.00%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	77,153	46	77153	0.72%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	273,302	170	273302	0.75%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	48,263	1	48263	0.02%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	14,068	5	14068	0.43%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	158,265	142	158265	1.08%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	44,126	25	44126	0.68%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	264,722	173	264722	0.78%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	92,445	3	92445	0.04%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	26,693	11	26693	0.49%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	297,607	258	297607	1.04%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	121,279	71	121279	0.70%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	538,024	343	538024	0.77%
QI	UHCCP	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	44,182	1	44182	0.03%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	12,625	0	12625	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	139,342	34	139342	0.29%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	77,153	8	77153	0.12%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	273,302	43	273302	0.19%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	48,263	0	48263	0.00%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	14,068	2	14068	0.17%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	158,265	22	158265	0.17%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	44,126	4	44126	0.11%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	264,722	28	264722	0.13%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	92,445	1	92445	0.01%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	26,693	2	26693	0.09%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	297,607	56	297607	0.23%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	121,279	12	121279	0.12%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	538,024	71	538024	0.16%
QI	UHCCP	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Outpat 0-12 F Pct	Admin	584,395	2,022	584395	4.15%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 13-17 F Pct	Admin	195,346	1,951	195346	11.98%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 18-64 F Pct	Admin	1,056,320	14,440	1056320	16.40%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 65+ F Pct	Admin	164,574	895	164574	6.53%
QI	Statewide	MPTA	Mental Health Utilization	Outpat Tot F Pct	Admin	2,000,635	19,308	2000635	11.58%
QI	Statewide	MPTA	Mental Health Utilization	Outpat Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Outpat 0-12 M Pct	Admin	628,627	2,727	628627	5.21%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 13-17 M Pct	Admin	211,965	1,658	211965	9.39%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 18-64 M Pct	Admin	911,167	10,125	911167	13.33%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 65+ M Pct	Admin	100,238	546	100238	6.54%
QI	Statewide	MPTA	Mental Health Utilization	Outpat Tot M Pct	Admin	1,851,997	15,056	1851997	9.76%
QI	Statewide	MPTA	Mental Health Utilization	Outpat Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Outpat 0-12 Tot Pct	Admin	1,213,022	4,749	1213022	4.70%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 13-17 Tot Pct	Admin	407,311	3,609	407311	10.63%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 18-64 Tot Pct	Admin	1,967,487	24,565	1967487	14.98%
QI	Statewide	MPTA	Mental Health Utilization	Outpat 65+ Tot Pct	Admin	264,812	1,441	264812	6.53%
QI	Statewide	MPTA	Mental Health Utilization	Outpat Tot Tot Pct	Admin	3,852,632	34,364	3852632	10.70%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	MPTA	Mental Health Utilization	Outpat Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Any 0-12 F Pct	Admin	584,395	2,027	584395	4.16%
QI	Statewide	MPTA	Mental Health Utilization	Any 13-17 F Pct	Admin	195,346	1,995	195346	12.26%
QI	Statewide	MPTA	Mental Health Utilization	Any 18-64 F Pct	Admin	1,056,320	14,754	1056320	16.76%
QI	Statewide	MPTA	Mental Health Utilization	Any 65+ F Pct	Admin	164,574	1,030	164574	7.51%
QI	Statewide	MPTA	Mental Health Utilization	Any Tot F Pct	Admin	2,000,635	19,806	2000635	11.88%
QI	Statewide	MPTA	Mental Health Utilization	Any Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Any 0-12 M Pct	Admin	628,627	2,750	628627	5.25%
QI	Statewide	MPTA	Mental Health Utilization	Any 13-17 M Pct	Admin	211,965	1,687	211965	9.55%
QI	Statewide	MPTA	Mental Health Utilization	Any 18-64 M Pct	Admin	911,167	10,486	911167	13.81%
QI	Statewide	MPTA	Mental Health Utilization	Any 65+ M Pct	Admin	100,238	610	100238	7.30%
QI	Statewide	MPTA	Mental Health Utilization	Any Tot M Pct	Admin	1,851,997	15,533	1851997	10.06%
QI	Statewide	MPTA	Mental Health Utilization	Any Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Any 0-12 Tot Pct	Admin	1,213,022	4,777	1213022	4.73%
QI	Statewide	MPTA	Mental Health Utilization	Any 13-17 Tot Pct	Admin	407,311	3,682	407311	10.85%
QI	Statewide	MPTA	Mental Health Utilization	Any 18-64 Tot Pct	Admin	1,967,487	25,240	1967487	15.39%
QI	Statewide	MPTA	Mental Health Utilization	Any 65+ Tot Pct	Admin	264,812	1,640	264812	7.43%
QI	Statewide	MPTA	Mental Health Utilization	Any Tot Tot Pct	Admin	3,852,632	35,339	3852632	11.01%
QI	Statewide	MPTA	Mental Health Utilization	Any Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Intensive 0-12 F Pct	Admin	584,395	0	584395	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 13-17 F Pct	Admin	195,346	12	195346	0.07%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 18-64 F Pct	Admin	1,056,320	88	1056320	0.10%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 65+ F Pct	Admin	164,574	0	164574	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Tot F Pct	Admin	2,000,635	100	2000635	0.06%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Intensive 0-12 M Pct	Admin	628,627	0	628627	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 13-17 M Pct	Admin	211,965	8	211965	0.05%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 18-64 M Pct	Admin	911,167	130	911167	0.17%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 65+ M Pct	Admin	100,238	0	100238	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Tot M Pct	Admin	1,851,997	138	1851997	0.09%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Intensive 0-12 Tot Pct	Admin	1,213,022	0	1213022	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 13-17 Tot Pct	Admin	407,311	20	407311	0.06%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 18-64 Tot Pct	Admin	1,967,487	218	1967487	0.13%
QI	Statewide	MPTA	Mental Health Utilization	Intensive 65+ Tot Pct	Admin	264,812	0	264812	0.00%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Tot Tot Pct	Admin	3,852,632	238	3852632	0.07%
QI	Statewide	MPTA	Mental Health Utilization	Intensive Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	ED 0-12 F Pct	Admin	584,395	9	584395	0.02%
QI	Statewide	MPTA	Mental Health Utilization	ED 13-17 F Pct	Admin	195,346	40	195346	0.25%
QI	Statewide	MPTA	Mental Health Utilization	ED 18-64 F Pct	Admin	1,056,320	174	1056320	0.20%
QI	Statewide	MPTA	Mental Health Utilization	ED 65+ F Pct	Admin	164,574	6	164574	0.04%
QI	Statewide	MPTA	Mental Health Utilization	ED Tot F Pct	Admin	2,000,635	229	2000635	0.14%
QI	Statewide	MPTA	Mental Health Utilization	ED Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	ED 0-12 M Pct	Admin	628,627	10	628627	0.02%
QI	Statewide	MPTA	Mental Health Utilization	ED 13-17 M Pct	Admin	211,965	30	211965	0.17%
QI	Statewide	MPTA	Mental Health Utilization	ED 18-64 M Pct	Admin	911,167	223	911167	0.29%
QI	Statewide	MPTA	Mental Health Utilization	ED 65+ M Pct	Admin	100,238	8	100238	0.10%
QI	Statewide	MPTA	Mental Health Utilization	ED Tot M Pct	Admin	1,851,997	271	1851997	0.18%
QI	Statewide	MPTA	Mental Health Utilization	ED Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	ED 0-12 Tot Pct	Admin	1,213,022	19	1213022	0.02%
QI	Statewide	MPTA	Mental Health Utilization	ED 13-17 Tot Pct	Admin	407,311	70	407311	0.21%
QI	Statewide	MPTA	Mental Health Utilization	ED 18-64 Tot Pct	Admin	1,967,487	397	1967487	0.24%
QI	Statewide	MPTA	Mental Health Utilization	ED 65+ Tot Pct	Admin	264,812	14	264812	0.06%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	MPTA	Mental Health Utilization	ED Tot Tot Pct	Admin	3,852,632	500	3852632	0.16%
QI	Statewide	MPTA	Mental Health Utilization	ED Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Inpat 0-12 F Pct	Admin	584,395	43	584395	0.09%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 13-17 F Pct	Admin	195,346	181	195346	1.11%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 18-64 F Pct	Admin	1,056,320	567	1056320	0.64%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 65+ F Pct	Admin	164,574	147	164574	1.07%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Tot F Pct	Admin	2,000,635	938	2000635	0.56%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Inpat 0-12 M Pct	Admin	628,627	31	628627	0.06%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 13-17 M Pct	Admin	211,965	95	211965	0.54%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 18-64 M Pct	Admin	911,167	699	911167	0.92%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 65+ M Pct	Admin	100,238	74	100238	0.89%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Tot M Pct	Admin	1,851,997	899	1851997	0.58%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Inpat 0-12 Tot Pct	Admin	1,213,022	74	1213022	0.07%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 13-17 Tot Pct	Admin	407,311	276	407311	0.81%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 18-64 Tot Pct	Admin	1,967,487	1,266	1967487	0.77%
QI	Statewide	MPTA	Mental Health Utilization	Inpat 65+ Tot Pct	Admin	264,812	221	264812	1.00%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Tot Tot Pct	Admin	3,852,632	1,837	3852632	0.57%
QI	Statewide	MPTA	Mental Health Utilization	Inpat Unk Tot Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 0-12 F Pct	Admin	584,395	27	584395	0.06%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 13-17 F Pct	Admin	195,346	82	195346	0.50%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 18-64 F Pct	Admin	1,056,320	429	1056320	0.49%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 65+ F Pct	Admin	164,574	16	164574	0.12%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Tot F Pct	Admin	2,000,635	554	2000635	0.33%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Unk F Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 0-12 M Pct	Admin	628,627	44	628627	0.08%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 13-17 M Pct	Admin	211,965	38	211965	0.22%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 18-64 M Pct	Admin	911,167	171	911167	0.23%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 65+ M Pct	Admin	100,238	5	100238	0.06%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Tot M Pct	Admin	1,851,997	258	1851997	0.17%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Unk M Pct	Admin	0	0	0	NA
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 0-12 Tot Pct	Admin	1,213,022	71	1213022	0.07%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 13-17 Tot Pct	Admin	407,311	120	407311	0.35%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 18-64 Tot Pct	Admin	1,967,487	600	1967487	0.37%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth 65+ Tot Pct	Admin	264,812	21	264812	0.10%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Tot Tot Pct	Admin	3,852,632	812	3852632	0.25%
QI	Statewide	MPTA	Mental Health Utilization	Telehealth Unk Tot Pct	Admin	0	0	0	NA
QI	AlohaCare	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	988	106	988	10.73%
QI	AlohaCare	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	93	5	93	5.38%
QI	HSMA	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	2,691	279	2,691	10.37%
QI	HSMA	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	99	15	99	15.15%
QI	KFHP	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	291	9	291	3.09%
QI	KFHP	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	46	2	46	4.35%
QI	'Ohana	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	961	177	961	18.42%
QI	'Ohana	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	241	35	241	14.52%
QI	UHCCP	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	1,037	126	1,037	12.15%
QI	UHCCP	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	674	52	674	7.72%
QI	Statewide	OHD	Use of Opioids at High Dosage in Persons Without Cancer	18–64 Years	Admin	5,968	697	5,968	11.68%
QI	Statewide	OHD	Use of Opioids at High Dosage in Persons Without Cancer	65+ Years	Admin	1,153	109	1,153	9.45%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	793	59	793	7.44%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	391	34	391	8.70%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	525	50	525	9.52%

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Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	1,709	143	1,709	8.37%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	793	67	793	8.48%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	391	39	391	9.89%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	525	60	525	11.40%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	1,709	166	1,709	9.70%
QI	AlohaCare	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	793	59	67	0.88
QI	AlohaCare	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	391	34	39	0.88
QI	AlohaCare	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	525	50	60	0.84
QI	AlohaCare	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	1,709	143	166	0.86
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	24,215	34	24,215	1.40
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	5,803	14	5,803	2.41
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	5,586	29	5,586	5.19
QI	AlohaCare	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	35,604	77	35,604	2.16
QI	HSMA	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	1,232	111	1,232	9.01%
QI	HSMA	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	746	73	746	9.79%
QI	HSMA	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	939	86	939	9.16%
QI	HSMA	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	2,917	270	2,917	9.26%
QI	HSMA	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	1,232	106	1,232	8.58%
QI	HSMA	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	746	77	746	10.39%
QI	HSMA	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	939	109	939	11.59%
QI	HSMA	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	2,917	292	2,917	10.01%
QI	HSMA	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	1,232	111	106	1.05
QI	HSMA	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	746	73	77	0.94
QI	HSMA	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	939	86	109	0.79
QI	HSMA	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	2,917	270	292	0.92
QI	HSMA	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	55,071	36	55,071	0.65
QI	HSMA	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	13,274	23	13,274	1.73
QI	HSMA	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	12,910	24	12,910	1.86
QI	HSMA	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	81,255	83	81,255	1.02
QI	KFHP	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	237	19	237	8.02%
QI	KFHP	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	144	16	144	NA
QI	KFHP	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	182	22	182	12.09%
QI	KFHP	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	563	57	563	10.12%
QI	KFHP	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	237	20	237	8.43%
QI	KFHP	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	144	15	144	NA
QI	KFHP	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	182	21	182	11.31%
QI	KFHP	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	563	55	563	9.83%
QI	KFHP	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	237	19	20	0.95
QI	KFHP	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	144	16	15	NA
QI	KFHP	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	182	22	21	1.07
QI	KFHP	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	563	57	55	1.03
QI	KFHP	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	8,583	8	8,583	0.93
QI	KFHP	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	2,087	6	2,087	2.87
QI	KFHP	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	2,132	7	2,132	3.28
QI	KFHP	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	12,802	21	12,802	1.64
QI	'Ohana	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	582	48	582	8.25%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	339	33	339	9.73%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	599	79	599	13.19%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	1,520	160	1,520	10.53%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	582	52	582	8.93%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	339	38	339	11.34%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	599	77	599	12.85%
QI	'Ohana	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	1,520	167	1,520	11.01%

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	582	48	52	0.92
QI	'Ohana	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	339	33	38	0.86
QI	'Ohana	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	599	79	77	1.03
QI	'Ohana	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	1,520	160	167	0.96
QI	'Ohana	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	11,337	16	11,337	1.41
QI	'Ohana	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	3,800	22	3,800	5.79
QI	'Ohana	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	4,871	24	4,871	4.93
QI	'Ohana	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	20,008	62	20,008	3.10
QI	UHCCP	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	365	38	365	10.41%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	278	28	278	10.07%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	437	46	437	10.53%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	1,080	112	1,080	10.37%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	365	34	365	9.30%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	278	31	278	11.31%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	437	55	437	12.53%
QI	UHCCP	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	1,080	120	1,080	11.12%
QI	UHCCP	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	365	38	34	1.12
QI	UHCCP	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	278	28	31	0.89
QI	UHCCP	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	437	46	55	0.84
QI	UHCCP	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	1,080	112	120	0.93
QI	UHCCP	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	16,852	18	16,852	1.07
QI	UHCCP	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	4,661	17	4,661	3.65
QI	UHCCP	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	5,552	25	5,552	4.50
QI	UHCCP	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	27,065	60	27,065	2.22
QI	Statewide	PCR	Plan All-Cause Readmissions	Observed Readmissions—18–44 Years*	Admin	3,209	275	3,209	8.57%
QI	Statewide	PCR	Plan All-Cause Readmissions	Observed Readmissions—45–54 Years*	Admin	1,898	184	1,898	9.69%
QI	Statewide	PCR	Plan All-Cause Readmissions	Observed Readmissions—55–64 Years*	Admin	2,682	283	2,682	10.55%
QI	Statewide	PCR	Plan All-Cause Readmissions	Observed Readmissions—Total*	Admin	7,789	742	7,789	9.53%
QI	Statewide	PCR	Plan All-Cause Readmissions	Expected Readmissions—18–44 Years*	Admin	3,209	279	3,209	8.69%
QI	Statewide	PCR	Plan All-Cause Readmissions	Expected Readmissions—45–54 Years*	Admin	1,898	201	1,898	10.58%
QI	Statewide	PCR	Plan All-Cause Readmissions	Expected Readmissions—55–64 Years*	Admin	2,682	321	2,682	11.97%
QI	Statewide	PCR	Plan All-Cause Readmissions	Expected Readmissions—Total*	Admin	7,789	801	7,789	10.28%
QI	Statewide	PCR	Plan All-Cause Readmissions	O/E Ratio—18–44 Years*	Admin	3,209	275	279	0.99
QI	Statewide	PCR	Plan All-Cause Readmissions	O/E Ratio—45–54 Years*	Admin	1,898	184	201	0.92
QI	Statewide	PCR	Plan All-Cause Readmissions	O/E Ratio—55–64 Years*	Admin	2,682	283	321	0.88
QI	Statewide	PCR	Plan All-Cause Readmissions	O/E Ratio—Total*	Admin	7,789	742	801	0.93
QI	Statewide	PCR	Plan All-Cause Readmissions	Outliers—18–44 Years*	Admin	116,058	112	116,058	0.97
QI	Statewide	PCR	Plan All-Cause Readmissions	Outliers—45–54 Years*	Admin	29,625	82	29,625	2.77
QI	Statewide	PCR	Plan All-Cause Readmissions	Outliers—55–64 Years*	Admin	31,051	109	31,051	3.51
QI	Statewide	PCR	Plan All-Cause Readmissions	Outliers—Total*	Admin	176,734	303	176,734	1.71
QI	AlohaCare	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	1,093	328	411	79.81%
QI	AlohaCare	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	1,093	362	411	88.08%
QI	HSMA	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	3,210	229	411	55.72%
QI	HSMA	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	3,210	319	411	77.62%
QI	KFHP	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	404	354	404	87.62%
QI	KFHP	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	404	401	404	99.26%
QI	'Ohana	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	367	246	367	67.03%
QI	'Ohana	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	367	319	367	86.92%
QI	UHCCP	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	571	324	411	78.83%
QI	UHCCP	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	571	376	411	91.48%
QI	Statewide	PPC	Prenatal and Postpartum Care	Postpartum Care	Hybrid	5,645	—	—	65.74%
QI	Statewide	PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	Hybrid	5,645	—	—	83.20%
QI	AlohaCare	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	376,157	60	376,157	15.95

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	38,419	4	38,419	10.41
QI	AlohaCare	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	414,576	64	414,576	15.44
QI	HSMA	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	956,104	143	956,104	14.96
QI	HSMA	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	50,465	7	50,465	13.87
QI	HSMA	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	1,006,569	150	1,006,569	14.90
QI	KFHP	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	149,347	17	149,347	11.38
QI	KFHP	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	11,084	2	11,084	18.04
QI	KFHP	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	160,431	19	160,431	11.84
QI	'Ohana	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	209,553	42	209,553	20.04
QI	'Ohana	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	46,332	7	46,332	15.11
QI	'Ohana	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	255,885	49	255,885	19.15
QI	UHCCP	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	297,971	66	297,971	22.15
QI	UHCCP	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	123,425	3	123,425	2.43
QI	UHCCP	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	421,396	69	421,396	16.37
QI	Statewide	PQI01	Diabetes Short-Term Complications Admission Rate	18–64 Years	Admin	1,989,132	328	1,989,132	16.49
QI	Statewide	PQI01	Diabetes Short-Term Complications Admission Rate	65+ Years	Admin	269,725	23	269,725	8.53
QI	Statewide	PQI01	Diabetes Short-Term Complications Admission Rate	Total	Admin	2,258,857	351	2,258,857	15.54
QI	AlohaCare	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	157,014	43	157,014	27.39
QI	AlohaCare	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	39,419	68	39,419	172.51
QI	AlohaCare	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	196,433	111	196,433	56.51
QI	HSMA	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	400,329	166	400,329	41.47
QI	HSMA	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	50,465	30	50,465	59.45
QI	HSMA	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	450,794	196	450,794	43.48
QI	KFHP	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	63,326	14	63,326	22.11
QI	KFHP	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	11,084	5	11,084	45.11
QI	KFHP	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	74,410	19	74,410	25.53
QI	'Ohana	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	110,859	70	110,859	63.14
QI	'Ohana	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	46,332	53	46,332	114.39
QI	'Ohana	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	157,191	123	157,191	78.25
QI	UHCCP	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	150,758	48	150,758	31.84
QI	UHCCP	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	123,425	80	123,425	64.82
QI	UHCCP	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	274,183	128	274,183	46.68
QI	Statewide	PQI05	COPD or Asthma in Older Adults Admission Rate	40-64 Years	Admin	882,286	341	882,286	38.65
QI	Statewide	PQI05	COPD or Asthma in Older Adults Admission Rate	65+ Years	Admin	270,725	236	270,725	87.17
QI	Statewide	PQI05	COPD or Asthma in Older Adults Admission Rate	Total	Admin	1,153,011	577	1,153,011	50.04
QI	AlohaCare	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	376,157	226	376,157	60.08
QI	AlohaCare	PQI08	Heart Failure Admission Rate	65+ Years	Admin	39,419	72	39,419	182.65
QI	AlohaCare	PQI08	Heart Failure Admission Rate	Total	Admin	415,576	298	415,576	71.71
QI	HSMA	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	956,104	355	956,104	37.13
QI	HSMA	PQI08	Heart Failure Admission Rate	65+ Years	Admin	50,465	49	50,465	97.10
QI	HSMA	PQI08	Heart Failure Admission Rate	Total	Admin	1,006,569	404	1,006,569	40.14
QI	KFHP	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	149,347	60	149,347	40.17
QI	KFHP	PQI08	Heart Failure Admission Rate	65+ Years	Admin	11,084	14	11,084	126.31
QI	KFHP	PQI08	Heart Failure Admission Rate	Total	Admin	160,431	74	160,431	46.13
QI	'Ohana	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	209,553	138	209,553	65.85
QI	'Ohana	PQI08	Heart Failure Admission Rate	65+ Years	Admin	46,332	79	46,332	170.51
QI	'Ohana	PQI08	Heart Failure Admission Rate	Total	Admin	255,885	217	255,885	84.80
QI	UHCCP	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	297,971	205	297,971	68.80
QI	UHCCP	PQI08	Heart Failure Admission Rate	65+ Years	Admin	123,425	167	123,425	135.30
QI	UHCCP	PQI08	Heart Failure Admission Rate	Total	Admin	421,396	372	421,396	88.28
QI	Statewide	PQI08	Heart Failure Admission Rate	18-64 Years	Admin	1,989,132	984	1,989,132	49.47
QI	Statewide	PQI08	Heart Failure Admission Rate	65+ Years	Admin	270,725	381	270,725	140.73
QI	Statewide	PQI08	Heart Failure Admission Rate	Total	Admin	2,259,857	1,365	2,259,857	60.40

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	AlohaCare	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	219,143	6	219,143	2.74
QI	HSMA	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	1,808,200	39	1,808,200	2.16
QI	KFHP	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	86,021	4	86,021	4.65
QI	'Ohana	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	98,694	5	98,694	5.07
QI	UHCCP	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	147,213	7	147,213	4.76
QI	Statewide	PQI15	Asthma in Younger Adults Admission Rate	Asthma in Younger Adults Admission Rate	Admin	2,359,271	61	2,359,271	2.59
QI	AlohaCare	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	282	150	282	53.19%
QI	AlohaCare	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	291	154	291	52.92%
QI	HSMA	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	442	246	442	55.66%
QI	HSMA	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	452	252	452	55.75%
QI	KFHP	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	69	43	69	62.32%
QI	KFHP	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	73	45	73	61.64%
QI	'Ohana	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	825	583	825	70.67%
QI	'Ohana	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	925	684	925	73.95%
CCS	'Ohana	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Admin	977	703	977	71.95%
QI	UHCCP	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	716	519	716	72.49%
QI	UHCCP	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	817	603	817	73.81%
QI	Statewide	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	19–64 Years	Admin	2,334	1,541	2,334	66.02%
QI	Statewide	SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	18+ Years	Admin	2,558	1,738	2,558	67.94%
QI	AlohaCare	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	Met
QI	AlohaCare	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	Met
QI	AlohaCare	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	Met
QI	HSMA	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	Met
QI	HSMA	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	Met
QI	HSMA	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	Met
QI	KFHP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	Met
QI	KFHP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	Met
QI	KFHP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	Met
QI	'Ohana	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	Met
QI	'Ohana	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	Met
QI	'Ohana	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	Met
QI	UHCCP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	Met

HI MY 2020 Performance Measure Rates
- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	Met
QI	UHCCP	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	Met
QI	Statewide	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Submitted to DHS/MQD	Admin	—	—	—	—
QI	Statewide	SBIRT	Screening, Brief Intervention, and Referral to Treatment	SBIRT Training Plan Recommendations from DHS/MQD Addressed	Admin	—	—	—	—
QI	Statewide	SBIRT	Screening, Brief Intervention, and Referral to Treatment	ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Admin	—	—	—	—
QI	AlohaCare	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	420	293	420	69.76%
QI	HSMA	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	904	626	904	69.25%
QI	KFHP	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	131	106	131	80.92%
QI	'Ohana	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	894	649	894	72.60%
QI	UHCCP	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	766	600	766	78.33%
QI	Statewide	SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	3,115	2,274	3,115	73.00%
QI	AlohaCare	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	1,134	1,072	1,134	94.53%
QI	AlohaCare	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	176	145	174	83.33%
QI	AlohaCare	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	4,068	4,047	4,067	99.51%
QI	HSMA	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	70,796	6,450	70,795	9.11%
QI	HSMA	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	1,256	444	1,256	35.35%
QI	HSMA	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	70,796	21,091	70,796	29.79%
QI	KFHP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	11,909	8,511	11,909	71.47%
QI	KFHP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	1,924	126	1,924	6.55%
QI	KFHP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	11,909	7,577	11,909	63.62%
QI	'Ohana	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	17,625	1,029	17,625	5.84%
QI	'Ohana	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	1,029	130	1,029	12.63%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	'Ohana	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	17,625	3,019	17,621	17.13%
QI	UHCCP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	25,330	1,797	25,329	7.09%
QI	UHCCP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	371	156	371	42.05%
QI	UHCCP	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	25,330	5,644	25,329	22.28%
QI	Statewide	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use	Admin	126,794	18,859	126,792	14.87%
QI	Statewide	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Identified as Tobacco User AND Received Tobacco Cessation Intervention	Admin	4,756	1,001	4,754	21.06%
QI	Statewide	TOBACCO	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Screened for Tobacco Use AND 1) Received Tobacco Cessation Intervention (If Tobacco User) or 2) Identified as Tobacco Non-User	Admin	129,728	41,378	129,722	31.90%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Hybrid	952	13	411	3.16%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Hybrid	952	8	411	1.95%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Hybrid	952	8	411	1.95%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Hybrid	952	16	411	3.89%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Hybrid	952	15	411	3.65%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Hybrid	952	47	411	11.44%
QI	AlohaCare	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Hybrid	952	304	411	73.97%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Hybrid	3,234	6	348	1.72%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Hybrid	3,234	2	348	0.57%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Hybrid	3,234	6	348	1.72%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Hybrid	3,234	13	348	3.74%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Hybrid	3,234	30	348	8.62%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Hybrid	3,234	43	348	12.36%
QI	HSMA	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Hybrid	3,234	248	348	71.26%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Admin	608	2	608	0.33%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Admin	608	5	608	0.82%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Admin	608	12	608	1.97%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Admin	608	10	608	1.64%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Admin	608	26	608	4.28%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Admin	608	71	608	11.68%
QI	KFHP	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Admin	608	482	608	79.28%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Hybrid	294	7	294	2.38%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Hybrid	294	5	294	1.70%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Hybrid	294	3	294	1.02%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Hybrid	294	11	294	3.74%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Hybrid	294	21	294	7.14%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Hybrid	294	28	294	9.52%
QI	'Ohana	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Hybrid	294	219	294	74.49%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Hybrid	399	12	399	3.01%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Hybrid	399	5	399	1.25%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Hybrid	399	5	399	1.25%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Hybrid	399	13	399	3.26%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Hybrid	399	23	399	5.76%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Hybrid	399	37	399	9.27%
QI	UHCCP	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Hybrid	399	304	399	76.19%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	No Well-Child Visits*	Mixed	5,487	—	—	1.95%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	One Well-Child Visit	Mixed	5,487	—	—	0.95%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	Two Well-Child Visits	Mixed	5,487	—	—	1.72%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	Three Well-Child Visits	Mixed	5,487	—	—	3.50%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	Four Well-Child Visits	Mixed	5,487	—	—	6.99%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	Five Well-Child Visits	Mixed	5,487	—	—	11.75%
QI	Statewide	W15	Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	Mixed	5,487	—	—	73.15%
QI	AlohaCare	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid	5,675	279	411	67.88%
QI	HSMA	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid	15,990	256	335	76.42%
QI	KFHP	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Admin	3,028	2,513	3,028	82.99%
QI	'Ohana	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid	1,597	247	388	63.66%
QI	UHCCP	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid	1,684	243	392	61.99%
QI	Statewide	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Mixed	27,974	—	—	73.80%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	33,126	170	205	82.93%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	20,166	107	130	82.31%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	53,292	277	335	82.69%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	33,126	170	205	82.93%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	20,166	107	130	82.31%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	53,292	277	335	82.69%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	33,126	170	205	82.93%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	20,166	107	130	82.31%
QI	AlohaCare	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	53,292	277	335	82.69%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	29,702	181	217	83.41%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	17,231	110	125	88.00%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	46,933	291	342	85.09%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	29,702	160	217	73.73%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	17,231	92	125	73.60%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	46,933	252	342	73.68%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	29,702	160	217	73.73%
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	17,231	92	125	73.60%

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	HSMA	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	46,933	252	342	73.68%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	5,449	72	74	97.30%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	3,065	43	46	93.48%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	8,514	115	120	95.83%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	5,449	74	74	100.00%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	3,065	44	46	95.65%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	8,514	118	120	98.33%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	5,449	73	74	98.65%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	3,065	44	46	95.65%
QI	KFHP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	8,514	117	120	97.50%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	2,133	185	230	80.43%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	1,080	95	118	80.51%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	3,213	280	348	80.46%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	2,133	174	230	75.65%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	1,080	88	118	74.58%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	3,213	262	348	75.29%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	2,133	166	230	72.17%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	1,080	86	118	72.88%
QI	'Ohana	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	3,213	252	348	72.41%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	2,643	239	273	87.55%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	1,352	116	138	84.06%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	3,995	355	411	86.37%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	2,643	220	273	80.59%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	1,352	106	138	76.81%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	3,995	326	411	79.32%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	2,643	207	273	75.82%

HI MY 2020 Performance Measure Rates

- Health Plan Specific Rates -

Reporting Unit	Plan	PM Code	Performance Measure	PM Indicator	Methodology	2020 Elig Pop	2020 Num	2020 Den	2020 Rate
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	1,352	106	138	76.81%
QI	UHCCP	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	3,995	313	411	76.16%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—3–11 Years	Hybrid	73,053	—	—	84.29%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—12–17 Years	Hybrid	42,894	—	—	85.40%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile Documentation—Total	Hybrid	115,947	—	—	84.69%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—3–11 Years	Hybrid	73,053	—	—	80.17%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—12–17 Years	Hybrid	42,894	—	—	79.40%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Nutrition—Total	Hybrid	115,947	—	—	79.87%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—3–11 Years	Hybrid	73,053	—	—	79.79%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—12–17 Years	Hybrid	42,894	—	—	79.35%
QI	Statewide	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Counseling for Physical Activity—Total	Hybrid	115,947	—	—	79.62%

*A lower rate indicates better performance.

— Indicates the rate cannot be displayed.

NA = The QI health plan followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate.

Met = The QI health plan met the data element criteria.

State of Hawai`i, Department of Human Services
CY 2019 QI Risk Share Calculation
Aggregate Health Care Expenses

	ABD	F&C	Expansion	Total
1. Member Months	655,656	2,094,778	1,306,733	4,057,166
3. Health Care Expense				
Incurred Claims				
Medical	$ 325,214,317	$ 426,875,157	$ 436,236,186	$ 1,188,325,659
Pharmacy	$ 77,254,430	$ 42,292,663	$ 103,442,136	$ 222,989,230
LTSS	$ 365,938,424	$ -	$ -	$ 365,938,424
Other Benefit Costs				
Subcapitation	$ 19,880,186	$ 27,716,392	$ 14,344,392	$ 61,940,970
Care coordination/case management	$ 39,819,792	$ 12,218,260	$ 13,310,199	$ 65,348,251
Provider incentive and bonus payments	$ 892,723	$ 2,057,923	$ 1,393,877	$ 4,344,523
Recoveries (TPL, subrogation, fraud, reinsurance)	$ (659,168)	$ (1,326,489)	$ (1,176,515)	$ (3,162,173)
Physician enhancement payments	$ 4,331,057	$ 12,389,077	$ 7,753,304	$ 24,473,438
Non-system payments (1)	$ 2,884,580	$ 4,069,986	$ 3,326,238	$ 10,280,804
Other medical/benefit costs (1)	$ 9,162,269	$ 2,569,960	$ 891,384	$ 12,623,613
Other Supplemental Rx Rebates	$ (2,929,334)	$ (2,565,259)	$ (4,970,743)	$ (10,465,335)
Total Health Care Expenses	**$ 841,789,276**	**$ 526,297,669**	**$ 574,550,459**	**$ 1,942,637,404**

(1) - For detail on what's included see Exhibits 1a, 2a, 3a, 4a, and 5a in "QI 2019 Risk Share Calculation Med-Quest 20210106.pdf"

Hawaii QUEST Integration

Federal Fiscal Year 2020 4th Quarter Information (DY26 Q4)

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: With 2020 Annual Report

Reporting Period: July 2020 – September 2020

Federal Fiscal Quarter:	4th Quarter 2020
State Fiscal Quarter:	1st Quarter 2021
Calendar Year:	3rd Quarter 2020
Demonstration Year:	26th Year (10/1/19–9/30/20)

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I. Introduction

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI 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 reporting period, MQD continued to focus on a comprehensive health care delivery system transformation, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings.

MQD plans to procure a new QI contract effective July 1, 2021, with a targeted release of the QI Request for Proposal (RFP) in the last quarter of 2020. On July 21, 2020, MQD issued a Request for Information (RFI) for community needs, best practices, and resources. MQD received 37 responses from stakeholders and the public. All responses

are available on the Med-QUEST website: medquest.hawaii.gov. Ongoing regular meetings have been continuing for the "HOPE Leadership Team" to discuss specific language changes to the QI Request for Proposal (RFP). Recent meetings have focused on refining the care coordination/service coordination model for the new QI RFP, to ensure alignment with HOPE goals.

MQD leadership continued targeted communications with QI health plans (Health Plans) during the Public Health Emergency (PHE). The Task Force that began meeting three times a week in the spring reduced the meeting frequency to two times a week and now in this latest quarter transitioned to meeting once a week, with an enhanced focus on ensuring the Home and Community Based Services (HCBS) residential settings have the Personal Protective Equipment (PPE) needed to prevent the spread of the COVID-19 virus (COVID-19). Ensuring compliance with the FFCRA provisions around continuing Medicaid eligibility and approved services, expanding telehealth access to services, and monitoring provider network adequacy during the PHE were other priorities during the Task Force meetings. The Medicaid Director continued to meet with Health Plan CEOs once a week to discuss high-level issues around COVID-19, and MQD continued weekly meetings with Health Plan CFOs to discuss financing impacts to Health Plans and to providers as a result of COVID-19.

MQD resources and activities during this reporting period were heavily focused on issues and interventions related to COVID-19. Multiple policy and guidance memos were sent to Health Plans and providers. MQD also worked with CMS partners to submit and obtain approval for 1135, 1115, and 1915© flexibilities during the PHE. After partnering last quarter with state emergency entities, QI Health Plans, and provider agencies to acquire and distribute 30,000 surgical masks, over 1500 pairs of gloves, 1250 shoe coverings, and hand sanitizer to the foster homes as preventative PPE, MQD developed a PPE 'go-kit' to deploy to community residential settings when there is a COVID+ or suspected COVID+ case. A 'Go-kit' contains a 14-day supply of PHE for primary and secondary caregivers in COVID-19+ homes – including disposable gloves, surgical masks, face shields, surgical gowns, shoe coverings, and use instructions – and are distributed one per member to the caregivers. This is in recognition of the negative impact that sick caregivers and secondary caregivers would have on provider capacity in the HCBS residential settings.

Finally, in alignment with Hawaii statewide efforts to reduce the spread of COVID-19, MQD continued to enable its staff to work from home wherever feasible and practical. This was in recognition that each staff is going through different requirements and family situations, and that one size does not fit all. During the August month when Hawaii experienced a bump in COVID cases, there was a further move by staff away from working in the office toward working from home.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality Workbook for the quarter ending June 30, 2020 was submitted to CMS by the August 31, 2020 deadline. The Budget Neutrality Summary (worksheet) for the quarter ending September 30, 2020 will be submitted separately by the November 30, 2020 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

During this reporting period, the Medicaid Ombudsman contract was awarded to Koan and implemented on September 1, 2020. Koan continues to provide Ombudsman services to both managed care Health Plan members and providers.

B. Benefits & Benefit Changes

Compliance with Section 1115 Demonstration Special Terms and Conditions

CMS approved several documents during the fourth quarter. The Hawaii COVID-19 Public Health Emergency Demonstration was approved on June 25, 2020, the Hawaii Behavioral Health Services Protocol was approved on September 1, 2020, the update to Hawaii QUEST Integration Emergency Preparedness and Response Attachment K with an Addendum was approved on September 25, 2020 and the required Preprint addressing the temporary retainer payments in the Attachment K was approved on September 24, 2020. MQD is working on implementation for all approved documents both internally and with the MCO's.

HOPE Initiative

HOPE initiative and other MQD staff continue to work with our consultants, stakeholders and other parties to develop implementation plans for the initiatives outlined in our HOPE document and the MCO RFP. Some of the areas of focus included identifying ways to address social risk factors through the care and service coordination process, improving access to behavioral health services across the continuum, supporting palliative care, and developing additional strategies to support advanced primary care models. PPDO also participated in the development of the Quality Strategy. All of these efforts required intensive discussions with various teams and the consultants assigned to this task.

Monitoring implementation of eligibility provisions under the Family First Coronavirus Response Act (FFCRA) and Public Health Emergency (PHE)

PPDO has been very involved with MQD administration and staff to ensure continued receipt of the 6.2% FMAP offered to states who abide by the provisions in the FFCRA as well as the numerous waivers allowed under the PHE to ensure continuation of coverage for our beneficiaries and reduction of barriers to our applicants. This has been an extremely coordinated and intense effort between the KOLEA systems office, Eligibility Branch, Systems office and our Finance Office, as well as continuous guidance and dialogue with CMS, and has continued since last quarter. We will continue to monitor these provisions while also beginning discussions of best ways to transition back to "pre-COVID-19" rules and regulations once the PHE has ended.

Collaboration with the Department of Education (DOE) to increase Medicaid Claiming for School Based Services

Med-QUEST continues collaboration with DOE for Medicaid Claiming issues. The main focus for this quarter has been finalizing provider enrollments, resolving claiming issues, and continuing working on Administrative Claiming and a school health services SPA with CMS. The work has been challenging due to COVID-19 issues taking precedence.

Medicaid Eligibility Quality Control (MEQC) and the federal Payment Error Rate Measurement (PERM) program

These programs had been suspended in April 2020 due to PHE but were resumed effective August 11, 2020. The review focuses on 3 components: the claims processing via HPMMIS, Medical Reviews involving Providers, and

Eligibility Determination for Medicaid/CHIP programs for Review Year 2021 which is claims paid during July 2019 through June 20, 2020 are subject for review. PPDO has been leading and coordinating roles, responsibilities and responses to CMS in preparation for these two programs for the past few months, but action has intensified during this quarter.

PPDO assisted with Hawaii's Quality Control Office by providing MCERP results and documentation to assist with MEQC proposal which shall be conducted in-between PERM review years. The MEQC review mandated by CMS to demonstrate Corrective Action Procedure goals in efforts to correct the error findings discovered during PERM reviews are met to reduce error findings exceeding the 3% National Averaged allowed. Hawaii's MEQC proposal was due early November 2020, which was submitted and acknowledgement of receipt by CMS was received as of last week. MEQC reviews will begin January 1, 2021 through December 31, 2021 upon receipt of CMS' approval for the proposed MEQC process.

Hawaii Administrative Rules

PPDO continues work amending the Hawaii Administrative Rules as well as the Medicaid State Plan to ensure compliance with new federal and state regulations and guidelines.
State Plan Amendment 19-0005 was approved and issued 07/23/2020 regarding updated Durable Medical Equipment rates.

No Hawaii Administrative Rules were amended, however, during this period. However, as summarized in the first paragraph of this section, several waiver documents were approved during this quarter.

Policy and Program Directives

PPD 20-005 "Death Payments Program" was issued 09/21/20. This PPD is being used to clarify eligibility requirements for an unclaimed body under the provisions of Hawaii Administrative Rules (HAR) Chapter 17-1745-4. In addition, fillable forms (DHS 1123, DHS 1128 DHS 1133, DHS 1135, DHS 1136, DHS 1137, DHS 1148 DHS 1151, 1161 and DHS 1163) were made available for MQD and provider use online. DHS 1139 (interim) was updated to use with the new HOKU provider enrollment system issued. PPDO also assisted with BPMO P&P regarding the Forms Management Program.

To inform providers of specific policy changes, the following provider memos were released during this period:

- **QI-2032** Medicaid Fee-For-Service Hospice Rates - Effective October 1, 2020 through September 30, 2021 (09/28/20)
- **QI-2031** QUEST Integration (QI) Transition of Care (TOC) Files (09/08/20)
- **QI-2030** Medicaid Fee-For-Service Hospice Nursing Facilities Rates - Effective July 1, 2020 (08/12/20)
- **QI-2029** HOKU COVID-19 Waivers and Policy Reminders (07/28/20)
- **QI-2028** Clarification on Applied Behavior Analysis (ABA) Services Through Telehealth (07/21/20)
- **QI-2027** Required Quantity Prescribed Field in Point of Sale Claim Submission for Schedule II Drugs (07/13/20)
- **QI-2026** Medicaid Rates for Legacy Hilo Rehabilitation and Nursing Center (7/10/20)
- **QI-2025** Universal Precautions for QUEST Integration Members Receiving At-Risk and Home and Community Based Services (Addendum to FFS-M15-05) (7/28/20)
- **QI-2024** Subacute Definitions (Replaces QI-2012, QI-2012A) (7/15/20)
- **QI-2023** Medicaid Rates for Island Skilled Nursing and Rehabilitation (7/8/20)

PPDO continues the work of ensuring programs and policies align with State initiatives and continues to broaden collaborative efforts with other divisions, offices and other both public and private entities, and continues to be a collaborative member of the KALO leadership teams.

Additional Work Projects

PPDO partners with the Health Care Services Branch on various projects, initiatives, and issues that have direct impact on benefits in the 1115 Demonstration Waiver. This quarter we have worked on reviewing options for alignment with the Dual Special Needs Plan population, overseeing the MCO's development of a joint telehealth plan for all Medicaid providers and members to utilize (if approved by MQD), and addressing issues related to Hospice Services, concurrent review of inpatient hospital stays, and implementation of a new state law affecting adolescent mental health services.

C. Enrollment and Disenrollment

The Customer Service Branch (CSB), Eligibility Branch (EB), and Health Care Outreach Branch (HCOB) are committed to assist community members complete their Medicaid application and pre-enroll in a QUEST Integration health plan. Since the pandemic, Med-QUEST enhanced technology for staff, includes issuing of laptops with virtual private network and installed Voice Over Internet Protocol (VoIP) in EB offices located on Oahu and Maui. VoIP increased the amount of staff available to answer calls from the public, whether working in-office or remotely, complete an application and pre-select a QI health plan or answer questions about enrollment. A pre-selection completes the application and ensures immediate enrollment when applicant is deemed eligible for Medicaid. HCOB manages community activity and ensures navigators follow the same process as Med-QUEST staff with assisting the public.

1. Enrollment Summary

As of September 30, 2020, the following table represents the percentage increase of applications during the PHE.

Count	2019	2020	Percentage Increase in Applications
Honolulu	26,149	33,388	28%
Maui	5,784	9,138	58%
Hawaii	7,610	8,808	16%
Kauai	2,598	4,061	56%
Statewide	42,141	55,395	31%

[Member Choice of Health Plan Exercised, appears in section XII.A.]

2. Disenrollment Summary

There were 49 approved plan changes outside the normal choice period for members. Med-QUEST approved plan changes for 7 beneficiaries. Health plans agreed to 42 plan change requests received by its members.

	# of Beneficiaries	Reason
Beneficiaries that requested plan-to-plan change with cause	17	**11 Continuity of Care** ○ 11 primary care physician not participating with plan **6 Service coordination** ○ 2 beneficiaries changed plan to match Medicare Advantage ○ 1 continuity with commercial plan (TPL). ○ 2 behavioral health providers ○ 1 Newbor1 reassigned to health plan offered by the same insurer as non-Medicaid mothers commercial health plan
Beneficiaries that requested plan-to-plan change without cause	42	
Beneficiaries that changed health plan after being auto-assigned	3,869	

D. Quality of Care

See EQRO information in section XIV. (Quality Assurance and Monitoring Activity).

E. Access that is Relevant to the Demonstration

MQD worked to expand the availability of telehealth during the PHE. MQD issued additional clarifying guidance for the delivery of Applied Behavioral Analysis (ABA) services via telehealth. Additional codes were considered as deliverable via telehealth, and factors for consideration were outlined for providers when allowing ABA services via telehealth. This guidance can be found in memo QI-2028 issued on July 21, 2020.

MQD issued memorandum in FFY 2020 Q2 outlining the data requirements around Community Integration Services (CIS) for our homeless population. In the current quarter MQD has taken additional steps to further define CIS policy around housing assessments, housing support/crisis plans, service authorizations, billing and payment, credentialing and contracting, program integrity and documentation, and member disenrollment. Near the end of September, MQD shared with community partners and MCOs a draft of this subsequent memo that will cover criteria, processes, and codes for these services. Specific feedback on this draft was requested.

MQD has regular meetings with sister divisions that are a part of the Hawaii Department of Health (DOH), including Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division (ADAD), Adult Mental Health Division (AMHD), and Developmental Disabilities Division (DDD). The goal of these meetings is to align and coordinate the behavioral health services that QI members receive with existing services that are available through DOH. These productive meetings have continued to inform QI RFP language changes.

F. Pertinent Legislative or Litigation Activity

The Hawaii state legislature began normal sessions in January 2020. However, due to the PHE it abruptly ended. No pertinent legislation was passed because of the closure. MQD participates in two active Legislative Taskforces, one involving physical health and mental health integration and the other involving hospitalizations of the serious mental illness population. With the current PHE in place these Legislative Taskforces have been on hiatus.
There are a number of ongoing workgroups that were established by the legislature that MQD is participating in including: Earned Income Disregard Program; Intellectual and Developmental Disabilities Medicaid Waiver Administrative Claiming Special Fund which requires MQD and DOH to engage with stakeholders to develop and distribute information about accessing Medicaid services; and a Behavioral Health Care Workgroup.

MQD was notified during the 3rd quarter of FFY 2019 of being party to a lawsuit along with the Children and Adolescent Mental Health Division, Dept. of Health for the provision of mental health services for a child/young adult. There has been no substantive MQD activity related to this case during this reporting period.

MQD is pursuing litigation regarding a drug, Plavix, for which MQD believes the manufacturers withheld critical information on drug efficacy as it relates to patient ethnicity. Several key MQD employees were deposed in the 2nd quarter of FFY 2020. This case was scheduled to go to court in the 1st quarter of FFY 2021.

IV. Grievances and Appeals

A. Grievance Events that Affect Health Care Delivery

See section IV.B. (Member Grievances and Appeals Filed During the Reporting Period by Type), below.

B. Member Grievances and Appeals Filed During the Reporting Period by Type

The following tables provide grievance and appeal events received during this reporting period.

1. Grievances to MQD Health Care Services Branch (HCSB)

July 2020 – September 2020 **Types of Member Grievances to HCSB**	
Description: The following are grievances received by the HCSB of MQD. These DO NOT include the grievances received by the Health Plans, which are reported in a separate table below.	
Health Plan Policy	0
Provider/Provider Staff Behavior/Services	3
Transportation Customer Service	5
Treatment Plan/Diagnosis	1
Fraud and Abuse of Services	1

Billing/Payments	1
Member Rights	3
Medication	2
General Information	10
Forward to Other Departments	3
Total	**29**

Some grievances fit into multiple categories.

Month	# of Member Grievances to HCSB by Month
July 2020	6
August 2020	12
September 2020	11
Total	**29**

Status of Member Grievances Addressed by HCSB					
		July 2020	August 2020	September 2020	TOTAL
Received		5	4	15	24
Status					
Referred to Subject Matter Expert		1	1	4	6
Health Plan resolved with Members		2	1	2	5
Member withdrew grievance		0	0	1*	1
Resolution in Health Plan favor		2	2	4	8
Resolution in Member's favor		0	0	1	1
Still awaiting resolution		0	0	2	2
Return to Health Plan awaiting Resolution Letter		0	0	2	2
Carry-over from previous Quarter		2	0	10	12

*Individual was asked to contact Medicaid but her services were from Medicare. Sent letter to clarify this for member.

2. Grievances to Health Plans

Member Complaints/Grievances to Health Plan	
	Jul-Sep 2020
Total number filed during the reporting period	287
Total number that received timely acknowledgement from health plan	278
Total number not receiving timely acknowledgement from health plan	3
Total number expected to receive timely acknowledgement during next reporting period	9
Total number that received timely decision from health plan	268
Total number not receiving timely decision from health plan	1
Total number expected to receive timely decision during next reporting period	7
Total number currently unresolved during the reporting period	18
Total number overturned	0

Types of Member Complaints/Grievances Reported to Health Plan	
Medical	**Jul–Sep 2020**
Provider Policy	6
Health Plan Policy	35
Provider/Provider Staff Behavior	72
Health Plan Staff Behavior	32
Appointment Availability	7
Network Adequacy/ Availability	4
Waiting Times (office, transportation)	59
Condition of Office/ Transportation	4
Transportation Customer Service	13
Treatment Plan/Diagnosis	34
Provider Competency	20
Interpreter	0
Fraud and Abuse of Services	2
Billing/Payments	19
Health Plan Information	8
Provider Communication	17
Member Rights	20
Total	316

3. Appeals to Health Plans

During July 2020 – September 2020, there were a total of 300 Appeals submitted with the Health Plans.

Member Appeals to Health Plans	
	TOTAL
Total number filed during the reporting period	300
Total number that received timely acknowledgement from health plan	269
Total number not receiving timely acknowledgement from health plan	9
Total number expected to receive timely acknowledgement during next reporting period	22
Total number that received timely decision from health plan	265
Total number not receiving timely decision from health plan	2
Total number expected to receive timely decision during next reporting period	33
Total number currently unresolved during the reporting period	33
Total number overturned	168

Types of Member Appeals to Health Plans	
	TOTAL
Service denial	43
Service denial due to not a covered benefit	9
Service denial due to not medically necessary	241
Service reduction, suspension or termination	0
Payment denial	8
Timeliness of service	0

Prior authorization timeliness	0
Other	4

4. Appeals to the State (State Fair Hearings)

There was a total of 6 Appeals submitted to AAO. Five (5) were resolved prior to going to a hearing, and one (1) was resolved in DHS's favor.

Types of Member Appeals to State Administrative Appeals Office (AAO)					
		Jul 2020	Aug 2020	Sep 2020	**TOTAL**
Medical		0	4	0	4
Home and Community Based Services (HCBS)		1	0	0	1
Van Modification		0	0	0	0
Applied Behavioral Analysis (ABA)		0	0	0	0
Durable Medical Equipment		0	0	0	0
Reimbursement		0	0	0	0
Medication		1	0	0	1
Miscellaneous		0	0	0	0

Status of Member Appeals to State Administrative Appeals Office (AAO)					
		Jul 2020	Aug 2020	Sep 2020	**TOTAL**
Submitted		2	4	0	6
Status received from AAO					
Department of Human Services (DHS) resolved with health plan or Department of Health Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing		1	4	0	5

Dismiss as untimely filing		0	0	0	0
Member withdrew hearing request		0	0	0	0
Resolution in DHS' favor		0	0	0	0
Resolution in Member's favor		0	0	0	0
Still awaiting resolution		1	0	0	1

V. Adverse Incidents

A. Long Term Services and Supports (LTSS)

The LTSS category includes a number of different provider types such as Community Care Foster Family Homes (CCFFHSs), Extended Adult Residential Care Homes (EARCHs), ICF DD/ID facilities and nursing facilities.

For July 2020 - September 2020, there were 367 adverse events from the Health Plans, 13 from the Nursing Facilities, and 11 from the ICF DD/ID. The "Fall" category remains the top occurring incident.

	Health Plan	Nursing Facility	ICF DD/ID	TOTAL
Fall	132	10	1	143
Hospital	104	0	0	104
Death	32	0	0	32
Emergency Room Visit	55	0	5	60
Injury	44	3	4	51
Med Error		0	1	1
TOTAL	367	13	11	391

VI. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data

MQD conducts a monthly encounter validation meeting with all participating MCOs to address major issues in encounter data submission or validation. Ongoing engagement supports a continuous data quality improvement initiative aimed at decreasing the number of encounters that fail system edits. MQD has developed an encounter reconciliation process directly with the MCOs that accounts for financial discrepancies between encounters submitted by the MCOs and accepted by MQD. The protocol for this reconciliation process has undergone iterative improvements, and the reconciliation is conducted at least twice per year. Substantial work has also begun to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. MQD is currently working with its contracted actuary, Milliman, to refine a reconciliation process that will also compare encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. This process has been conducted on an ad hoc basis in the past but will be folded into an ongoing reconciliation process conducted annually. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.
In addition to encounter data reconciliation, MQD has also worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing for high cost newborns is based on encounters found within the State Medicaid encounter system. Beginning in 2019, risk sharing for high cost drugs will also be based on encounters found within the State Medicaid encounter system. Beyond these measures, MQD has also built new provisions into the managed care re-procurement RFP to enhance oversight into encounter data submissions during the next contract cycle.
During FFY 2020 4th Quarter, MQD continued to refine a process for addressing ongoing challenges our MCOs experience with submitting encounter data into the system. The following projects were implemented in FFY 2020 Quarter 4.

1) MQD continued planning for a funding request to implement encounter data validation supports to improve encounter data validation, processing, investigations, and support from AHCCCS.

2) MQD has made substantial progress in a contract with its EQRO to conduct an external encounter data validation project. The project includes a full assessment of the Hawaii encounter pend system, including pend system edits; describes in detail the current process by which MCOs prepare files for MQD and the data challenges experienced or incurred as a result; and result in a full data quality profile of Hawaii encounter data along with the development of a data quality protocol that may be implemented by MQD to track improvements in quality as processes are refined and improved.

VII. Action Plans for Addressing Issues Identified In:

A. Policy

During the reporting period, implementation of the Appendix K and 1135 Emergency Waiver amendments were completed. CMS approved multiple submissions by the State of Hawaii. The Hawaii Behavioral Health Services Protocol was approved on September 1, 2020, the update to Hawaii QUEST Integration Emergency Preparedness

and Response Attachment K with an Addendum was approved on September 25, 2020 and the required Preprint addressing the temporary retainer payments in the Attachment K was approved on September 24, 2020. MQD is working on implementation for all approved documents both internally and with the MCO's. An action plan for transition of cases is being drafted in preparation for the termination of the health pandemic emergency (HPE) period, which was extended to January 22, 2021.

B. Administration

Med-QUEST is working with the New England States Consortium Systems Organizations (NESCSO) for the implementation of an AVS system leveraging NESCSO's contract with Public Consulting Group (PCG). Med-QUEST, NESCSO, and PCG held a Kick-off Meeting on April 16, 2020 to initiate the project and successfully implemented an AVS Portal on July 27, 2020. While Med-QUEST implemented an AVS Portal on July 27, 2020, the State has decided not to operationalize use of the portal at this time out of consideration for the training and change management challenges during this time of the public health emergency.

The State instead will focus on training and using available resources towards the AVS integration into the Medicaid eligibility system targeted for December 2020. Integration will be implemented using a phased strategy informed by a combination of implementation challenges and pending policy decisions. Unlike accessing a stand-alone portal, direct integration between the Medicaid system and an AVS system requires an interface to transmit and receive data and system logic to facilitate automation of verification of assets. Integration also requires involved security and infrastructure development for direct integration. The decision to implement using a phased approach was also informed by the State's pending decisions regarding the appropriate use of AVS data, including clarification from CMS on best practices. The State believes this strategy allows the state more time for policy decisions, to understand best practices, to implement the complex interface logic and rules for verification, and to execute adequate training and change management for users to adopt the new technology and processes.
Phase I will implement an interface between the Medicaid system and the AVS system to facilitate automated requests to and from the AVS system. AVS response data will be presented to workers in the Medicaid system for their review. Phase II will automate the verification and eligibility steps of the process, eliminating the need for workers to manually review AVS response data.

When operationalized, AVS Integration Phase I will require AVS at time of application, renewal, and changes in circumstances for all individuals subject to asset verification under section 1940 of the Social Security Act. Phase I also includes integration of a monthly bank file listing all financial institutions available via the AVS, data conversion of existing bank information to aid in verification of existing beneficiary asset information, and a number of enhancements to the user interface that include new task workflows and views to display AVS data. Phase II introduces intelligent rules for automated verification and eligibility determinations triggered by logic and rules that will evaluate asset details against thresholds and holding/transfer periods.
The State of Hawaiʻi believes that pursuant to section 1903(i)(24) of the Social Security Act (the Act), execution of this phased implementation plan brings the State into compliance with federal requirements under section 1940 of the Act within 12 months of our approval of this CAP.

C. Budget

See section IX. (Financial and Budget Neutrality Development and Issues), below.

VIII. Expenditure Containment Initiatives

No new containment initiatives for this reporting period.

IX. Financial and Budget Neutrality Development and Issues

For this reporting period, there were prior period adjustments for capitation payments due to retroactive rate changes for a portion of the first half of calendar year 2020. These were not issues that need to be resolved and are merely being noted.

X. Monthly Enrollment Reports for Demonstration Participants

A. Enrollment Counts

		Member Months	**Unduplicated Members**
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**Jul 2020 – Sep 2020**	**Jul 2020 – Sep 2020**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	366,486	120,850
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	114,499	37,021
Aged	Aged w/Medicare Aged w/o Medicare	88,782	29,674
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	73,255	24,372
Expansion State Adults	Expansion State Adults	332,425	107,420
Newly Eligible Adults	Newly Eligible Adults	69,199	22,218
Optional State Plan Children	Optional State Plan Children	0	0

Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,786	578
Medically Needy Adults	Medically Needy Adults	0	0
Demonstration Eligible Adults	Demonstration Eligible Adults	0	0
Demonstration Eligible Children	Demonstration Eligible Children	0	0
VIII-Like Group	VIII-Like Group	0	0
UCC-Governmental	UCC-Governmental	0	0
UCC-Governmental LTC	UCC-Governmental LTC	0	0
UCC-Private	UCC-Private	0	0
CHIP	CHIP (HI01), CHIPRA (HI02)	86,035	28,560
Total		**1,132,467**	**370,693**

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	212,495
Title XXI funded State Plan	28,560
Title XIX funded Expansion	129,638
Enrollment current as of	9/30/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending 9/30/20**
EG 1 – Children	**121,211**	**123,009**	**124,052**	**368,272**
EG 2 – Adults	**37,562**	**38,313**	**38,624**	**114,499**
EG 3 – Aged	**29,321**	**26,642**	**29,819**	**88,782**
EG 4 – Blind/Disabled	**24,369**	**24,345**	**24,541**	**73,255**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**130,024**	**134,764**	**136,836**	**401,624**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 9/30/20
State Plan Children	120,626	122,418	123,442	366,486
State Plan Adults	37,562	38,313	38,624	114,499
Aged	29,321	29,642	29,819	88,782
Blind or Disabled	24,369	24,345	24,541	73,255
Expansion State Adults	108,011	111,401	113,013	332,425
Newly Eligible Adults	22,013	23,363	23,823	69,199
Optional State Plan Children	0	0	0	0
Foster Care Children, 19-20 years old	585	591	610	1,786
Medically Needy Adults	0	0	0	0
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children	0	0	0	0
VIII-Like Group	0	0	0	0
UCC-Governmental	0	0	0	0
UCC-Governmental LTC	0	0	0	0
UCC-Private	0	0	0	0

C. Enrollment in Behavioral Health Programs

Point-in-Time (1st day of last month in reporting quarter)

Program	# of Individuals
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,682**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**818**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**874**

D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) enrollment reported by the health plans is as follows.

Health Plan	Jul 2020	Aug 2020	Sep 2020
Aloha Care	541	566	507
HMSA	744	759	680
Kaiser	301	307	306
Ohana	2717	2611	1874
United Healthcare	2209	2177	2089
Total	**6512**	**6420**	**5456**

Plan-to-plan change requests and results, specifically for LTSS members, are not tracked. The QI program includes LTSS services amongst its benefits.

XI. Outreach and Innovative Activities

The Health Care Outreach Branch (HCOB), together with our Community Partners have reached out to more than 200 businesses in Hawaii such as, Local Unions, hotels, car rental companies, Restaurants, Bars, Visitor Industry businesses, Hawaiian Airlines, Ranches, Farms and numerous small mom and pop businesses who have laid off employees due to the pandemic. Some businesses closed permanently; others did furloughs. Our outreach team conducted virtual Zoom/Microsoft Teams presentations to either the HR administration or the staff directly to educate them on their health options with Medicaid and the Federal Health Insurance Marketplace. We provided contact information for all our community partners statewide who could assist them with the enrollment process. We also assisted many residents with enrollment due to the sheer number of people who had lost their health coverage during this public health emergency.

HCOB worked with community partners to ensure a smooth transition of health coverage for justice involved populations, by working closely with the Department of Public Safety to help unsuspend coverage or reapply those who were being released, due to the COVID-19 situation. During this period the HCOB team was able to suspend/unsuspend, submit applications and supplemental forms for over 62 inmates. This pandemic has put a tremendous stress on our residents who have mental health/behavioral health challenges and our branch worked closely with the Hawaii State Hospital to ensure we were helping to seamlessly suspend and/or unsuspend patients health coverage with Med-QUEST. During this period, we assisted over 74 patients.

HCOB worked with our Kokua Services Contractors in Maui County to conduct drive-in outreach and education sessions and reached over 100 individuals and families to help apply residents for coverage and for many, to help inform and prepare residents of the required documents and information to bring with them or have on hand for the upcoming Marketplace Open Enrollment, November 1 – December 15, 2020. Hawaii has many residents who are lawfully present under five years and from the Federated States of Micronesia, The Republic of Palau and The Republic of the Marshall Islands (those nations under the Compact of Free Association). These residents who are healthy, not pregnant, blind or disabled, and are 19 through 64 years of age do not qualify for Medicaid. HCOB along with our community partners help them to apply and enroll or renew their coverage through the Marketplace along with determining whether they meet all the criteria and are eligible for the Hawaii State Funded Premium Assistance Program (PAP). Those who are eligible, qualify for advance premium tax credits to help with a share of the monthly premium, and a 94% cost share reduction subsidy which helps lower out-of-pocket expenses, and they must apply and enroll in a Silver Level plan on the Marketplace. Eligible residents have their remaining monthly premium cost covered by the PAP.

XII. Number of Participants who Chose an MCO and Number of Participants who Changed MCO After Auto-Assignment

A. Member Choice of Health Plan Exercised

July 2020 – September 2020	Number of Members
Individuals who chose a health plan when they became eligible	**2,551**
Individuals who were auto-assigned when they became eligible	**9,641**
Individuals who changed their health plan after being auto-assigned	**3,869**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**42**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**13**

During this reporting period, 2,551 individuals chose their health plan since they became eligible in the previous quarter, 3,869 changed their health plan after being auto-assigned. In addition, 13 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

XIII. Demonstration Evaluation and Interim Findings

During FFY 2020 4th Quarter, MQD's Health Analytics Office (HAO) continued to work closely with CMS to make minor revisions to the draft evaluation design for the 2019-2024 1115 waiver to ensure that the draft aligned with CMS expectations. The UH team worked on addressing CMS comments in preparation for submission of a final evaluation design to CMS. In addition, HAO prepared and submitted a draft evaluation design to CMS to support the PHE 1115 Demonstration ("Hawaii COVID-19 Public Health Emergency Demonstration" - 11-W-00351/9).

XIV. Quality Assurance and Monitoring Activity

A. Quality Activities

The External Quality Review Organization (EQRO) oversees the health plans for the Quest Integration (QI) and Community Care Services (CCS) programs. Health Services Advisory Group (HSAG), the EQRO, performed the following activities this quarter:

1. Validation of Performance Improvement Projects (PIPs)

July:
- Requested Module 4 intervention progress updates from Kaiser on 07/07/20 and Ohana on 07/14/20.
- Provided feedback on the Module 4 intervention progress updates from AlohaCare and Ohana Quest on 07/10/20.
- Provided feedback on the Module 4 intervention progress update from United Health Care on 07/20/20.
- Received a Module 4 intervention progress update from Kaiser on 07/24/20.
- Provided technical assistance to Kaiser on 07/30/20.

August:
- Received approval on the draft PIP reports from the MQD on 08/26/20.
- Provided technical assistance to Ohana CCS and Ohana Quest (FUH PIP) on 08/11/20 and also provided high level review feedback for those PIPs on 08/13/20.
- Received Ohana CCS and Ohana Quest (FUH PIP) intervention progress updates on 08/21/20.
- Requested Module 4 intervention progress updates from Kaiser (AWC PIP) and HMSA on 08/03/20.
- Provided technical assistance to Kaiser (AWC PIP) on 08/10/20 and 08/14/20.
- Received Kaiser (AWC PIP) intervention progress updates on 08/24/20.
- Provided Kaiser (FUH PIP) Module 4 intervention progress update feedback to the health plan on 08/05/20.
- Provided PIP training to the MQD staff on 08/24/20.

September:
- Sent final PIP reports to the MQD and the health plans by 09/03/20.
- Sent Ohana CCS FUH revised Modules 1-3 final validation tools and Module 4 intervention progress update feedback to the health plan on 09/03/20.
- Sent Ohana Quest FUH Module 4 intervention progress update feedback to the health plan on 09/03/20.
- Sent HMSA and Kaiser (AWC PIP) Module 4 intervention progress update feedback to the health plan on 09/11/20.
- Requested 2nd Module 4 intervention progress updates from Ohana Quest (WCV PIP), AlohaCare on 09/10/20 (updates due on 10/01/20), and from UHC on 09/24/10 (updates due on 10/25/20.)
- Provided TA via teleconference call to Kaiser (AWC PIP) on 09/16/20.
- Provided TA via email to AlohaCare (AWC PIP) on 09/21/20.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

July:
- HSAG submitted the Final Audit Reports to the MQD and the QI health plans by 07/15/20.

August:

- HSAG met with the MQD and the QI Health Plan Quality Leads on 07/20/21 to discuss CY 2020 Custom Measures for CY 2021 reporting.
- HSAG met with the MQD on 07/28/20 to further discuss MY 2020 performance measure reporting.
- HSAG sent the MQD the MY 2019 P4P measures spreadsheet on 07/31/20.

September:

- HSAG worked with the MQD to define the scope of HEDIS Measurement Year (MY) 2020 audits; identified the audited and non-audited performance measures by 09/04/20.

3. Compliance Monitoring

July:

- Conducted virtual compliance site reviews for all five QI plans and CCS:
    - Ohana QI – July 27, 2020
    - United Health Care – July 21, 2020
    - KFHP – July 23, 2020
    - Aloha Care – July 29, 2020
    - HMSA – July 22, 2020
    - Ohana CCS – July 28, 2020
- Began drafting compliance review reports

August:

- Completed draft compliance review reports and submitted reports to the MQD for review on 08/21/20.

September:

- Received MQD feedback on the compliance review reports on 09/10/20.
- Submitted draft compliance review reports to the health plans for review on 09/10/20.
- Received health plan feedback on the compliance review reports on 09/22/20.
- Submitted final compliance review reports to the MQD and the health plans on 09/28/20.
- Submitted corrective action plan tools to the health plans on 09/28/20.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

July:

- Performed Star Report survey data analysis on 07/02/20.
- Prepared data files for the MQD on 07/02/20.
- Submitted Star Reports to the MQD on 07/09/20.
- Submitted the respondent-level data files and data dictionary for each QI health plan and CHIP to the MQD on 07/09/20.
- HSAG notified the MQD that submission of the 2020 CAHPS data to the CAHPS Health Plan Survey Database was completed on 07/10/20.
- Performed comprehensive survey data analysis by 07/31/20.

August:

- Compiled the draft reports on 08/13/20.
- Submitted the draft reports and crosstabulations to the MQD on 08/24/20.

September:

- Received approval on draft reports from the MQD, including confirmation on the number of printed copies of each report the MQD will require, on 09/04/20.
- Submitted final reports electronically to the MQD and health plans and shipped the requested number of hard copies to the MQD on 09/15/20.

5. Provider Survey

July:

- Followed up with MQD on outstanding items on 07/16/20.

August:

- Received additional feedback from the MQD on Kaiser and non-Kaiser survey instruments on 08/12/20.
- Sent updated Kaiser and non-Kaiser survey instruments based on the MQD's feedback and received final approval on 08/13/20.
- Sent updated sample frame file instructions to the MQD on 08/20/20.
- Finalized survey notification process with the MQD on 08/20/20.

September:

- None at this time.

6. Annual Technical Report

July:

- Prepared report template sections and instructions to EQR activity team members.

August:

- Distributed report templates to HSAG activity leads on 08/25/20.

September:

- Began compiling/analyzing data and incorporating HSAG's findings, conclusions, and recommendations into the draft EQR technical report sections.
- Submitted revised technical report workplan to the MQD for approval on 09/27/20. Received approval from the MQD on 09/28/20.

7. Technical Assistance

July:

- Provided technical assistance to the Health Analytics Office (HAO) as needed.
- Conducted meeting with the HAO regarding patient-level data files on 07/01/20.
- Met with AlohaCare on 07/13/20 to provide guidance on performance measure reporting.
- Conducted meeting with the HAO, HSAG analytics team, and the HSAG performance measure validation team to discuss P4P and non-P4P Rate Submission on 07/15/20.
- Submitted proposed activity timeline and budget for patient level data (PLD) activities

August:

- Provided technical assistance to the Health Analytics Office (HAO) as needed.

- Received approval from the MQD on the proposed activity timeline and budget for patient level data (PLD) activities in 2020 and 2021 on 08/07/20.
- Notification letter with PLD activity information approved by the MQD on 08/17/20 and sent to the health plans on 08/21/20.
- Conducted training on mandatory and optional EQR activities for the MQD staff on 08/24/20.

September:

- Provided technical assistance to the MQD and Health Analytics Office (HAO) as needed.
- Completed validation of the MY2019 P4P Quality Pool Weighting and submitted to the HAO on 09/03/20.
- Began creating the patient level data specifications based on the approved MY2020 measures list.

XV. Quality Strategy Impacting the Demonstration

MQD contracted with a vendor, Myers & Stauffer, to work on updating quality strategy to align with the new QI RFP and HOPE Initiatives. MQD received a draft of the quality strategy from Myers & Stauffer during the month of March and circulated it for internal review by HAO, HCSB and the Clinical Standards Office (CSO). MQD had received internal and public comments on the Quality Strategy. MQD is preparing the final Quality Strategy document for submission to CMS in October 2020.

XVI. Other

Status of Current QUEST Integration and Other Contracts

During this period, MQD received final approval from CMS on QI RFP supplemental change #s 13 and 14. MQD also submitted supplemental change #15, which includes the QI Capitation rate from January 2021 to December 2021. MQD is ready to provide information to CMS for final approval.

Provider Management System Upgrade (PMSU)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD has moved forward with upgrading existing provider management software. A PMSU vendor, CNSI, was selected in FFY 2018 quarter three, and we received approval of this vendor contract in FFY 2019 quarter one. The Internal Verification & Validation (IVV) vendor was selected in FFY 2018 quarter four, to monitor the PMSU project. The initial go-live date of August 26, 2019 was postponed until March 2, 2020, to account for unforeseen complexities in business rules development and software coding and implementation. The go-live date was then postponed to April 13, 2020 to ensure thorough testing of the system. As we approached April 13, MQD and AHCCCS decided to postpone the go-live date due to the COVID-19 public health emergency (PHE). There have been further discussions on the new and final go-live date.

MQD named the PMSU project, Hawaii's Online Kahu Utility (HOKU). Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or pastor, one who looks after their flock. Med-QUEST providers are caretakers looking after and taking care of members.

MQD communicated an addendum memo (QI-2006B) to the MCOs and providers that included information about the new go-live date, updated registration in HOKU by waves, updated information about training materials and schedule and what an application ID is.

MQD issued a request for proposal in 2019 to secure a vendor for our Provider Enrollment and Revalidation contract. MQD awarded the contract to Koan, with an effective contract date of January 1, 2020. With the Provider Enrollment and Revalidation contract, Koan is responsible with managing MQD's provider hotline, imaging (scanning) provider applications and assisting with screening and inputting provider enrollment and revalidation applications.

MQD hired a new tech writer to continue the previous tech writer's work. The new tech writer worked on the provider training videos that will be available on MQD's HOKU webpage. There will be a training video for each HOKU enrollment type (Group Biller, Individual Provider, Atypical Provider, Facility/Agency/Organization and Atypical Agency).

As the HOKU go-live date, August 3rd, is fast approaching, MQD continued to work hard to scan paper applications to a SharePoint site so that MQD and Koan staff can access applications from home and process new provider paper applications. MQD also continued to work in partnership with AHCCCS to identify and clean-up any conversion errors the defects that are detected in the system. MQD and AHCCCS met daily with CNSI to discuss and fix the system's defects. A goal for MQD and AHCCCS is to have very little to none priority 1 defects found. MQD worked on provider communications and updated the website. In preparation of the new launch date, MQD hosted HOKU refresher courses for provider training session trainers (MCO staff) and MQD/Koan internal staff.

In the second month of this quarter (August) HOKU went live. MQD launched HOKU in phases (Waves) to prevent an overflow of applications entering the system at once. On August 3rd, HOKU was available to new Medicaid providers (enrolling for the first time) and our Wave 0 plans/organizations, Kaiser and Hawaii Pacific Health, who have internal administrative staff that enroll the providers for their plan/organization. MQD wanted to work in partnership with Kaiser and Hawaii Pacific Health to minimize the amount of external communication regarding provider application questions and issues. Before each Wave, MQD worked with our vendor, Cardinal, to mail the Application ID correspondences to each provider prior to each Wave start date. The Application ID letter informs the provider of their Application ID number and about registering in HOKU. The PMSUP vendor, CNIS, emailed Application ID letters to providers that MQD had an email address for. On August 10th, Wave 1 began, which included Group billers.

During the third month of this quarter (September), Wave 2 began on September 14th. This Wave included individual providers (except for MDs), Adult Foster Care providers, Home Care Agencies, Adult Day Health and Case Management Agencies. Same as Wave 1, Cardinal mailed out the Application ID correspondences prior to the September 14th and CNSI emailed Application ID letters.

During the first two months of HOKU's go-live period, MQD and Koan staff began to learn how to navigate HOKU, review applications and approve/deny applications in the live environment. MQD and Koan began meeting daily to discuss issues and ask questions. MQD and Koan also met a couple times each week with CNSI to discuss identified issues and request assistance for specific application review steps. As issues are identified and confirmed, MQD creates an incident ticket in CNSI's JIRA website. Once a ticket is created, CNSI triages the issue and responds/updates MQD.

Below are the provider application statistics as of the end of September.

Application Status	Number of Applications	Description
In Process	642	Number of applications providers are currently working on in HOKU but have not yet submitted.
In Review	250	Number of applications providers submitted in HOKU and are awaiting State Review.
Approved	184	Number of applications State reviewed and approved.

Also, during this quarter, MQD and trained Health Plan staff have begun webinar provider training sessions to demonstrate the process on how to fill out an application online in HOKU. Other training materials were also made available on the MQD's HOKU webpage, which included YouTube tutorial videos and PDF slide decks.
In the next quarter, the last two HOKU Waves will go-live for the providers included in those Waves. MQD and Koan staff will continue to meet internally and with CNSI to talk about issues and triage them to be solutioned. MQD is also prioritizing EVV providers to ensure providers are active and can move along with EVV project.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) is working towards the implementation of Electronic Visit Verification (EVV). In the federal fiscal year (FFY) 2020 Quarter 4 (Q4), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation.
During this quarter, the EVV Project Team completed and approved the User Acceptance Testing; which is the cornerstone for the EVV functionality as it reflects all the business rules configuration that are needed to support the EVV impacted programs. MCO self-directed training was held to start their training efforts. As EVV implementation draws near, stakeholder communications were increased through multiple methods. Member, provider, and authorization files were populated into the production EVV system.

MQD's future EVV workplans include:

Continue full engagement with the MCOs and provider agencies during the October - December soft launch. The team will continue working with the IV&V provider to ensure the Medicaid Enterprise Certification Lifecycle requirements are met as well as ensuring a successful implementation and certification of the EVV solution. The team will continue working with the EVV vendor towards an implementation date of December 30th, 2020.

JULY

During the month of July 2020, the AZ and HI EVV Project Teams continued to work the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. Demonstrated the EVV system to the provider agencies and MCOs. Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV timeline and project. Confirmed and approved the change in training approach from face-to-face to virtual due to COVID-19. The MCOs completed the authorization test cases with Sandata. Aligning with the Open Model approach, Alternate EVV vendor testing with Sandata began.

AUGUST

During the month of August 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification.
Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV project. Coordinated and developed a standardized provider EVV communication with the MCOs that was sent to the EVV providers. Collaborated with the MCOs to align provider contract renewals with the mandated EVV service codes and

modifiers. Finalized and approved the EVV training schedule. Met with the provider agencies to review the training schedule, authorization cutover and 3rd party EVV vendor requirements.

SEPTEMBER
Hosted two virtual EVV town hall meetings open to the public. Med-QUEST completed the Provider and Member file uploads into the EVV system. The MCOs completed the authorization file uploads into the EVV system. MCO claims validation testing began that compares a claim from a provider agency against the EVV database. 100% of the UAT test cases passed and the UAT approval was granted. Prepared the evidence packets for the Operational Readiness Review with CMS/MITRE. Identified and mitigated a catastrophic service code mapping error through execution of extensive end-to-end testing.

Clinical Care Guidelines

The Division continued to provide guidance to the managed care plans on the expansion of telehealth services during the public health emergency to allow increased access to care for recipients.

The Division worked with the Healthcare Association of Hawaii to update the subacute level of care definition with the goal of assisting hospitals and nursing facilities in the care of individuals at a subacute level of care. This was timely as it helped to facilitate movement of recipients from acute hospital beds to nursing facilities at a time when acute care beds are needed to address surges due to COVID-19 patients.

Another area that needed to be addressed due to Hawaii uniquely being made up of several islands, coordinate between Counties was needed related to travel and quarantine requirements as it related to COVID-19 protocols for recipients traveling between islands for medically necessary care. The policies were slightly different between Counties and affected access to care.

To address federal legislation related to MAT drugs and drug rebates the Division worked with health plans to identify and separate MAT drugs for drug rebate reports. The implementation date for separation of the drugs was October 1, 2020 and therefore work had to be done to ensure our State would be able to separate the MAT drugs so they were not submitted for rebates.

MQD Workshops and Other Events

Focus:	**HCBS Residential and COVID Meeting**		
For:	**Community Care Foster Family Homes (CCFFH)**		
Speaker	Curtis Toma, MQD Medical Director	**Location**	Go to Webinar
Length	1.5 hours	**Date**	August 6, 2020
Attendees	Approximately 155		
Description	An informational session to learn more about COVID, review preventative interventions, how to prepare the home to support isolation and quarantine, and discuss current challenges/issues.		

Focus:	Section 8 A Place Called Home		
For:	**MCO Service Coordinators and Homeless Provider Agency Staff**		
Trainer	City & County: Brian Minatoya/Gail Kaito	**Location**	Webinar
Length	2 hours per session	**Dates**	August 7, 2020- 1 session
Attendees	Approximately 240		
Description	An overview of City and county Section 8 application process, status and long-term maintenance of housing.		
Objectives/Outcomes	• Understand the application. How to help members apply. • Ensuring participation in C&C housing training for new recipients. • Interventions to assist members improve ability to maintain housing		

Focus:	HCBS Residential and COVID Meeting		
For:	**Community Care Foster Family Homes (CCFFH)**		
Speaker	Curtis Toma, MQD Medical Director	**Location**	Go to Webinar
Length	1.5 hours	**Date**	August 13, 2020
Attendees	Approximately 60		
Description	An informational session to learn more about COVID, review preventative interventions, how to prepare the home to support isolation and quarantine, and discuss current challenges/issues.		

Focus:	Person-Centered Organizations Leadership and Person-Centered Practices		
For:	MCO Service Coordination Supervisors, Trainers and Quality Staff		
Trainer	Bob Sattler, SDA	**Location**	Webinar
Length	1.5 hours per session	**Dates**	September 9, 2020- 1 session
Attendees	Approximately 60		
Description	Why look at Person Centered Changes in our organizations. How to start making changes.		
Objectives/Outcomes	• To examine Person Centered Practices from a Leadership perspective • To reframe the role of leaders		

Focus:	COVID 19 and Dementia		
For:	**Community Care Foster Family Homes (CCFFH) HCBS Medicaid Providers**		
Trainer	Aida Wen	**Location**	Webinar
Length	2 hours per session	**Dates**	September 22, 2020- 1 session
Attendees	Approximately 381		
Description	An interactive session to learn about **dementia** and how it can affect people's lives. Caregiver tips for socialization and recreation activities during COVID.		
Objectives/Outcomes	• Activities for residents in the home • Practice solutions to deal with difficult behaviors, including wandering. • Development of recreation plans in the CCFFH.		

Focus:	Person-Centered Organizations- 2		
For:	**MCO Service Coordination Supervisors, Trainers and Quality Staff and Service Coordinators**		
Trainer	Bob Sattler, SDA	**Location**	Webinar
Length	1.5 hours per session	**Dates**	September 30, 2020- 1 session
Attendees	Approximately 145		
Description	Continue to examine Person Centered Practices from a Leadership perspective and how to reframe the role of leaders		
Objectives/Outcomes	• Skills that contribute to change • Changing Process & Practice • Benefits from making changes • Making the plans for the organization		

Focus:	COVID 19 Updates for Medicaid Providers		
For:	**Case Managers and Residential Caregivers and MCO Service Coordination Supervisors**		
Trainer	Curtis Toma, MD/ QI Quality Staff	**Location**	Webinars
Length	1 hour per session (10 sessions)	**Dates**	March 23,2020 May 2020 June 8, 2020 July 9, 2020 July 27,2020 August 6, 2020 August 13,2020 September 24, 2020

			October 6, 2020 October 28, 2020
Attendees	Approximately 50-350+ based on content and target audience		
Description	COVID 19 Updates, Infection Control Trainings, Case Reporting, PPE and Flu Shot Distribution and Other Pertinent Discussion		
Objectives/Outcomes	• Ensure safe practices, supports and timely coordination to keep COVID infections in community residences low and eliminate COVID spread. • Facilitate access to PPE, testing, hospitals and nursing homes for caregivers and members • Engage, MCOS, home-caregivers and case manager to develop timely distribution mechanisms for PPE, Flu shots and other medical equipment statewide. • Provide updates on State COVID practices, stats and protocol changes. • Thank caregivers, vendors and MCOs for teamwork and implementation of effective COVID controls statewide.		

Focus:	**HOKU Provider Enrollment Training**		
For:	**Medicaid Providers**		
Speaker	Kelli Komatsu	**Location**	Go to Webinar
Length	1.5 hours	**Date**	June 29, 2020 to Present Every Tuesday and Thursday
Attendees	Approximately 155		
Description	On August 3, 2020, the Med-QUEST Division launched a new web-based provider enrollment system called HOKU. Training is provided to inform and assist providers in navigating the new system. Providers learn how to enroll, update, and make changes to their information online. This will reduce paper processing and will save time for both providers and State of Hawaii staff.		

A. Attachments

Attachment J1: 4th Q. FFY 2020 QUEST Integration Dashboard for July 2020 – September 2020
The QUEST Integration Dashboard compiles monthly data submitted by the Health Plans to MQD, regarding enrollment, network providers, call center calls, medical claims, prior authorizations, non-emergency transports, grievances, appeals, and utilization.

Attachment J2: 4th Q. FFY 2020 Up-To-Date Budget Neutrality Summary
The Budget Neutrality Summary (worksheet) for the quarter ending 6/30/2020 is attached. The Budget Neutrality Summary for the quarter ending 9/30/2020 will be submitted by the 11/30/2020 deadline.

Attachment J3: 4th Q. FFY 2020 Budget Neutrality Workbook
The Budget Neutrality Workbook for the quarter ending 06/30/2020 is attached. The Budget Neutrality Workbook for the quarter ending 9/30/2020 will be submitted by the 11/30/2020 deadline.

B. MQD Contact(s)

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QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jul-20					Aug-20					Sep-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	64,110	164,341	34252	27966	38,263	64,852	167,072	35792	28640	38,639	65,696	169,921	37245	28127	39,202
Duals	3,876	6,258	1518	9527	15,606	3,935	6,448	1585	9535	15,624	3,986	6,616	1650	9548	15,649
Total	**67,986**	**170,599**	**35770**	**37493**	**53,869**	**68,787**	**173,520**	**37377**	**38175**	**54,263**	**69,682**	**176,537**	**38895**	**37675**	**54,851**
# Network Providers															
PCPs	834	1,050	239	798	871	832	1,046	234	805	871	818	1,051	242	809	902
PCPs - (accepting new members)	705	841	223	**586**	616	703	847	218	**589**	616	692	847	224	**592**	617
Specialists	2,739	3,092	469	1547	1,590	2,736	3,110	468	1548	1,590	2,746	3,190	469	1551	1,621
Specialists (accepting new members)	1,920	3,092	469	**992**	1,443	1,918	3,110	468	**993**	1,443	1,928	3,190	469	**993**	1,484
Behavioral Health	856	1,682	134	668	1,040	841	1,685	121	669	1,040	849	1,692	120	672	1,058
Behavioral Health (accepting new members)	762	1,682	134	**627**	1,004	752	1,685	121	**627**	1,004	763	1,692	120	**627**	1,023
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	15	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	48	37	17	38	32	48	37	17	38	32	46	37	15	38	33
Residential Setting (CCFFH, E-ARCH, and ALF)	596	613	158	1051	1,205	604	608	145	1052	1,205	624	609	145	1052	1,195
HCBS Providers (except residential settings and LTSS facilities)	71	156	73	91	60	76	156	72	91	60	78	151	71	91	57
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,946	2,470	128	1780	1,786	1,939	2,478	122	1780	1,786	1,950	2,471	135	1780	1,802
Total # of providers	**7,115**	**9,127**	**1230**	**5,997**	**6,607**	**7,101**	**9,147**	**1191**	**6,007**	**6,607**	**7,136**	**9,228**	**1212**	**6,017**	**6,691**
Call Center															
# Member Calls	4,200	8,802	560	5,790	4,162	3,880	8,660	529	5,027	3,906	4,101	8,018	529	5,239	3,897
Avg. time until phone answered	0:00:09	0:00:22	0:00:09	0:00:20	0:00:12	0:00:09	0:00:07	0:00:09	0:00:35	0:00:09	0:00:09	0:00:09	0:00:07	0:00:19	0:00:16
Avg. time on phone with member	0:06:19	0:06:31	5:53	0:07:35	0:07:55	0:06:23	0:06:47	5:52	0:08:11	0:06:40	0:06:50	0:07:20	6:25	0:08:52	0:06:06
% of member calls abandoned (member hung up)	0.62%	2.07%	2%	2%	0.90%	0.67%	0.90%	1%	3%	1.50%	0.85%	1.22%	1%	2%	1.00%
# Provider Calls	7,074	6,015	70	3,043	2,581	6,518	5,544	76	2,615	2,318	6,665	5,594	84	2,683	2,406
Avg. time until phone answered	0:00:19	0:00:21	0:00:28	0:00:10	0:00:03	0:00:22	0:00:10	0:00:18	0:00:11	0:00:04	0:00:22	0:00:13	0:00:05	0:00:11	0:00:01
Avg. time on phone with provider	0:06:17	0:07:27	3:39	0:09:13	0:07:26	0:06:15	0:07:39	5:14	0:09:50	0:07:56	0:06:39	0:08:15	5:07	0:09:16	0:07:55
% of provider calls abandoned (provider hung up)	1.37%	1.41%	0%	2%	0.35%	1.92%	1.01%	0%	2%	0.35%	1.49%	1.16%	0%	1%	0.21%
Medical Claims- Electronic															
# Submitted, not able to get into system	2,514	1,687	0	2,610	3,890	2,004	1,640	0	2509	4,475	2,077	2,604	0	2610	3,587
# Received	49,205	150,635	28402	51372	77,582	48,771	149,655	31005	48325	80,621	49,117	154,554	34521	48607	80,150
# Paid	42,336	151,350	26210	46812	92,168	51,443	129,473	27291	43296	76,759	47,294	130,740	32207	41126	68,933
# In Process	14,140	38,163	1235	9780	13,033	7,648	48,327	2833	9619	1,391	6,605	61,991	1615	11640	1,695
# Denied	2,756	11,395	957	6762	7,933	3,148	9,939	881	5293	10,084	2,911	10,150	699	5312	9,309
Avg time for processing claim in days	7	9	1	5.7	4	6	9	1	6.1	6	7	9	1	5.75	5
% of electronic claims processed in 30 days	97%	98%	99.93	100%	100.0	98%	98%	99.96	100%	99.7	95%	98%	99.98	99.8	99.9
% of electronic claims processed in 90 days	100%	100%	99.95	100%	100.0	100%	100%	99.99	100%	100.0	100%	100%	100	99.9	100.0
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	256	1,947	0	285	849	270	1,239	3	102	1,148	286	1,424	4	116	501
# Received	14,588	14,283	12	4436	6,321	14,877	15,037	12	4007	7,208	14,359	14,722	8	3753	7,181
# Paid	13,292	14,056	7	5287	6,355	14,421	11,541	9	3439	5,679	14,009	10,401	8	2656	6,008
# In Process	5,425	6,338	1	1252	1,767	3,776	7,939	0	918	48	3,962	10,729	0	1238	150
# Denied	2,487	2,068	4	1592	1,375	2,038	1,885	3	922	1,406	1,861	1,531	0	781	1,409
Avg time for processing claim in days	12	15	1	9.85	4	11	14	62	10.35	6	11	16	20	10.5	5
% of electronic claims processed in 30 days	97%	94%	100.00	100%	99.8	98%	95%	75.00	99%	99.7	96%	94%	87.50	98.78	100.0
% of electronic claims processed in 90 days	99%	99%	100.00	100%	100.0	100%	99%	75.00	100%	100.0	100%	99%	87.50	99.36	100.0
Prior Authorization (PA)- Electronic															
# Received	183	2453	735	319	1,920	209	2297	690	876	1,810	202	2533	879	1,224	2,123
# In Process	24	332	31	192	156	26	400	20	271	138	62	548	44	505	134
# Approved	157	2,280	686	185	1,575	177	2,072	652	297	1,523	134	2,213	818	1,044	1,808
# Denied	32	172	18	20	189	44	157	18	16	149	61	172	17	13	181
Avg time for PA in days	0	3	3	2	1	1	4	2	8	0	1	4	3	15	2
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,527	591	0	1,572	96	1,679	487	0	1,165	71	1,810	574	0	1,135	98
# In Process	267	32	0	1,421	6	306	30	0	1,009	10	417	40	0	990	8
# Approved	1,201	531	0	1,524	81	1,316	426	0	1,132	59	1,337	499	0	1,113	65
# Denied	137	53	0	33	9	152	63	0	31	2	146	65	0	35	7
Avg time for PA in days	1	2	0	3	4	2	2	0	4	4	2	2	0	5	4
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3,704	4,588	541	5108	7,574	3,237	4,113	536	4774	7,079	3,026	3,868	624	4845	7,125
Air (by segment)	826	1,142	184	348	375	417	691	134	371	304	310	463	70	190	231
Public Transportation Pass (bus pass & handivan coupons)	1,347	1,021	431	1753	993	1,130	1,030	351	1546	867	1,361	800	548	1483	976
# Member Grievances															
# Received	15	12	10	12	21	11	15	8	20	38	17	17	24	24	25
# Resolved	17	19	9	20	29	14	8	12	12	27	13	18	13	1	29
# Outstanding	7	7	7	8	15	4	14	3	8	26	8	13	14	23	22
# Provider Grievances															
# Received	97	0	23	5	0	119	4	51	0	0	69	0	422	0	0
# Resolved	188	1	20	4	0	237	0	51	4	0	156	1	390	0	0
# Outstanding	948	0	3	1	0	823	4	0	0	0	736	3	32	0	0
# Member Appeals															
# Received	3	86	1	5	5	7	55	1	5	7	1	59	0	5	13
# Resolved	2	84	1	6	10	5	71	1	4	8	5	55	1	4	7

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jul-20					Aug-20					Sep-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Outstanding	3	34	1	0	1	5	18	1	3	0	1	22	0	4	6
# Provider Appeals															
# Received	25	10	0	37	63	15	13	0	44	41	18	17	0	33	61
# Resolved	37	13	0	52	78	46	10	0	54	43	34	15	0	26	56
# Outstanding	210	12	0	17	5	165	15	0	7	3	149	17	0	13	8
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	59	79	4	100	59	61	76	4	93	67	55	77	3	94	57
Inpatient Acute Days * (A) - per 1,000	271	232	20	712	446	329	229	20	629	469	271	248	17	636	412
Readmissions within 30 days* (A)	26	138	20	51	43	29	135	32	39	31	31	143	18	41	32
ED Visits * (C) - per 1,000**	376	312	22	591	477	386	296	21	605	458	354	268	19	528	425
# Prescriptions (C) - per 1,000	7,452	9,245	535	11,451	9,156	7,061	8,928	510	10,991	8,892	7,054	8,812	502	11,057	8,679
Waitlisted Days * (A) - per 1,000	24	2	1	51	160	34	2	3	45	174	30	4	2	17	117
NF Admits * (A)	42	16	0	12	35	49	14	4	17	30	41	14	2	12	30
# Members in NF (non-Medicare paid days) (C)**	258	270	83	696	726	262	279	91	645	720	233	280	91		706
# Members in HCBS **(C)- note: member can be included in more than one category listed below	283	474	218	2021	1,483	304	480	216	1966	1,457	274	400	215	1874	1,383
# Members in Residential Setting **(C)	141	124	134	542	928	157	129	146	534	887	165	141	141	499	878
# Members in Self-Direction **(C)	85	172	38	749	281	87	178	42	737	281	85	132	42	691	245
# Members receiving other HCBS **(C)	134	346	180	1272	1,287	153	375	174	1229	1,258	109	258	173	1183	139
# Members in At-Risk ** (C)	751	666	137	887	1,374	769	684	142	892	1,349	789	820	147	872	737
# Members in Self-Direction **(C)	328	302	39	380	503	332	325	36	385	489	339	397	37	393	454
# Members receiving other HCBS **(C)	316	651	98	397	1,038	364	760	106	402	997	323	801	110	444	287
(* non-Medicare) (**lag in data of two months)															

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility

Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.

PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

CMS 1500- physicians, HCBS providers eg.case management agencies, CCFFH/EARCH/ALF, home care agencies , 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.

QUEST Integration Health Plan Demographic Information by Island as of: 9/30/2020

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	468	83	22	12	66	81	86	818
PCPs - (accepting new members)	**392**	**72**	**19**	**10**	**55**	**69**	**75**	**692**
Specialists*	2000	281	25	0	175	77	188	2746
members)	**1415**	**181**	**12**	**0**	**119**	**55**	**146**	**1928**
Behavioral Health*	531	115	10	3	47	80	63	849
Behavioral Health (accepting new members)	**468**	**107**	**10**	**3**	**44**	**75**	**56**	**763**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	27	3	0	1	6	5	4	46
Residential Setting (CCFFH, E-ARCH, and ALF)	518	29	1	0	10	51	15	624
HCBS Providers (except residential settings and LTSS facilities)	41	10	4	3	5	10	5	78
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1256	241	27	14	142	129	141	1950
Totals	**4853**	**764**	**90**	**34**	**454**	**434**	**507**	**7136**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	39430	8780	2274	480	5722	6614	6382	**69682**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	84	106	103	40	87	82	74	85

Note: RFP requirement is 300 members for every PCP

HMSA

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	665	91	15	14	64	100	102	1,051
PCPs - (accepting new members)	525	69	13	9	50	86	95	**847**
Specialists*	1,921	309	70	43	177	318	352	3,190
members)	**1,921**	**309**	**70**	**43**	**177**	**318**	**352**	**3,190**
Behavioral Health*	1,054	203	8	7	93	192	135	1,692
Behavioral Health (accepting new members)	**1,054**	**203**	**8**	**7**	**93**	**192**	**135**	**1,692**
Hospitals	14	2	1	1	3	1	5	27
LTSS Facilities (Hosp./NF)	25	2	1	0	3	5	1	37
Residential Setting (CCFFH, E-ARCH, and ALF)	483	28	1	0	12	64	21	609
HCBS Providers (except residential settings and LTSS facilities)	71	18	8	6	13	24	11	151
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,589	267	32	21	172	167	223	2,471
Totals	**5.822**	**920**	**136**	**92**	**537**	**871**	**850**	**9.228**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	103158	12889	918	174	12038	28120	19240	**176,537**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	155	142	61	12	188	281	189	168

Note: RFP requirement is 300 members for every PCP

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	180	62						242
PCPs - (accepting new members)	**171**	**53**						**224**
Specialists*	373	96						469
members)	**373**	**96**						**469**
Behavioral Health*	102	18						120
Behavioral Health (accepting new members)	**102**	**18**						**120**
Hospitals	13	2						15
LTSS Facilities (Hosp./NF)	14	1						15
Residential Setting (CCFFH, E-ARCH, and ALF)	131	14						145
HCBS Providers (except residential settings and LTSS facilities)	56	15						71
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	96	39						135
Totals	**965**	**247**	**0**	**0**	**0**	**0**	**0**	**1212**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	25942	12953						**38895**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	144	209	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	161

Note: RFP requirement is 300 members for every PCP

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	552	51	9	10	73	71	43	809
PCPs - (accepting new members)	411	35	9	10	59	36	32	**592**
Specialists*	1168	108	13	4	113	76	69	1551
members)	708	88	13	4	53	66	61	**993**
Behavioral Health*	467	49	4	0	34	74	44	672
Behavioral Health (accepting new members)	448	34	3	0	34	68	40	**627**
Hospitals	11	2	1	1	3	1	5	24
LTSS Facilities (Hosp./NF)	23	3	1	1	5	2	3	38
Residential Setting (CCFFH, E-ARCH, and ALF)	883	41	0	0	18	85	25	1052
HCBS Providers (except residential settings and LTSS facilities)	51	8	2	0	4	20	6	91
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1120	180	15	6	131	172	156	1780
Totals	**4275**	**442**	**45**	**22**	**381**	**501**	**351**	**6017**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	23763	3808	403	97	2010	4638	2956	**37675**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	43	75	45	10	28	65	69	47

Note: RFP requirement is 300 members for every PCP

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	565	73	12	6	61	72	58	847
PCPs - (accepting new members)	**411**	**30**	**7**	**4**	**55**	**43**	**36**	**586**
Specialists*	1.246	165	65	9	111	199	175	1.970
members)	**1.130**	**151**	**49**	**9**	**102**	**185**	**164**	**1.790**
Behavioral Health*	759	245	61	64	169	239	201	1.738
Behavioral Health (accepting new members)	**732**	**242**	**61**	**64**	**166**	**236**	**198**	**1.699**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	23	2	0	0	3	4	1	33
Residential Setting (CCFFH, E-ARCH, and ALF)	983	53	2	0	23	110	24	1.195
HCBS Providers (except residential settings and LTSS facilities)	44	9	1	0	7	17	5	83
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1.300	247	15	12	142	186	160	2.062
Totals	**4930**	**797**	**157**	**92**	**519**	**831**	**627**	**7.953**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	36.053	4.694	274	98	2.984	6.941	3.807	**54.851**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	64	64	23	16	49	96	66	65

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls as of: 9/30/2020

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	74	10	2	0	7	12	5	**110**
Network (provider look up, access)	84	12	2	0	5	9	2	**114**
Primary Care Physician Assignment or Change	262	45	3	0	32	37	19	**398**
NEMT (inquiry, scheduling) -*monthly report*	427	32	10	5	12	48	22	**556**
Authorization/Notification (prior auth status)	525	44	12	2	24	50	16	**673**
Eligibility (general plan eligiblity, change request)	471	47	5	2	21	44	28	**618**
Benefits (coverage inquiry)	238	31	4	5	23	29	17	**347**
Enrollment (ID card request, update member information)	49	1	0	0	3	4	0	**57**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	294	26	2	0	14	24	14	**374**
Billing/Payment/Claims	652	60	4	1	19	24	13	**773**
Appeals	24	1	0	0	0	0	0	**25**
Complaints and Grievances	4	1	0	0	0	0	0	**5**
Other	218	39	2	2	13	26	5	**305**
Totals	**3,322**	**349**	**46**	**17**	**173**	**307**	**141**	**4,355**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	16	1	0	0	1	4	0	**22**
Network (provider look up, access)	123	17	0	0	14	28	23	**205**
Primary Care Physician Assignment or Change	1473	144	9	2	171	277	284	**2360**
NEMT (inquiry, scheduling) -*monthly report*	194	72	12	7	45	149	176	**655**
Authorization/Notification (prior auth status)	30	2	0	0	2	15	15	**64**
Eligibility (general plan eligiblity, change request)	350	50	3	2	38	74	68	**585**
Benefits (coverage inquiry)	325	71	2	0	37	57	62	**554**
Enrollment (ID card request, update member information)	675	74	2	1	75	186	144	**1157**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	24	6	0	0	1	8	8	**47**
Billing/Payment/Claims	170	25	1	0	20	22	39	**277**
Appeals	1	1	0	0	0	0	0	**2**
Complaints and Grievances	5	1	1	0	1	3	0	**11**
Other	420	76	3	0	62	112	116	**789**
Totals	**3806**	**540**	**33**	**12**	**467**	**935**	**935**	**6728**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	3	0						**3**
Network (provider look up, access)	31	13						**44**
Primary Care Physician Assignment or Change	3	3						**6**
NEMT (inquiry, scheduling) -*monthly report*	14	0						**14**
Authorization/Notification (prior auth status)	1	0						**1**
Eligibility (general plan eligiblity, change request)	164	34						**198**
Benefits (coverage inquiry)	104	39						**143**
Enrollment (ID card request, update member information)	32	11						**43**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	17	6						**23**
Appeals	0	0						**0**
Complaints and Grievances	0	0						**0**
Other	119	19						**138**
Totals	**488**	**125**	**0**	**0**	**0**	**0**	**0**	**613**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	289	50	3	0	11	94	22	**469**
Network (provider look up, access)	55	4	0	0	2	5	4	**70**
Primary Care Physician Assignment or Change	81	12	0	0	3	20	12	**128**
NEMT (inquiry, scheduling) -*monthly report*	1358	288	39	17	4	38	8	**1752**
Authorization/Notification (prior auth status)	21	13	10	0	2	24	7	**77**
Eligibility (general plan eligiblity, change request)	39	4	0	0	0	17	3	**63**
Benefits (coverage inquiry)	138	23	3	0	15	34	11	**224**
Enrollment (ID card request, update member information)	207	22	7	0	11	65	17	**329**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	88	12	3	0	3	32	6	**144**
Billing/Payment/Claims	25	5	0	0	0	11	3	**44**
Appeals	8	1	0	0	1	7	3	**20**
Complaints and Grievances	13	4	0	0	0	5	0	**22**
Other	1031	169	22	0	37	254	67	**1580**
Totals	**3,353**	**607**	**87**	**17**	**89**	**606**	**163**	**4,922**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	152	18	1	0	11	26	15	**223**
Network (provider look up, access)	70	18	0	0	5	28	6	**127**
Primary Care Physician Assignment or Change	428	75	2	5	45	116	63	**734**
NEMT (inquiry, scheduling) -*monthly report*	59	8	2	1	2	22	14	**108**
Authorization/Notification (prior auth status)	75	20	1	0	4	23	15	**138**
Eligibility (general plan eligiblity, change request)	413	50	0	4	24	92	43	**626**
Benefits (coverage inquiry)	537	61	0	1	42	86	52	**779**
Enrollment (ID card request, update member information)	138	23	0	0	6	29	13	**209**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	113	22	2	0	15	22	12	**186**
Billing/Payment/Claims	3	1	0	0	0	1	0	**5**
Appeals	8	1	0	0	3	4	1	**17**
Complaints and Grievances	4	0	0	0	0	0	0	**4**
Other	464	57	8	0	40	101	59	**729**
Totals	**2,464**	**354**	**16**	**11**	**197**	**550**	**293**	**3,885**

Health plan shall highlight changes made for the previous month(s)	
# Members	Description of Information to Include
Medicaid	Number of members receiving QI benefit package who do not have Medicare primary
Duals	Number of members receiving dual benefits
Total	Total number of members
# Network Providers	**Providers count on the "Dashboard" sheet should be un-duplicated. The providers counts on the "HP Demographics by Island" sheet may be duplicated when an individual provider serves multiple islands. Providers such as pharmacy services may be counted based upon number of locations. Non-Hawaii based network providers shall be excluded from all counts.**
PCPs	PCP count includes PCPs in the clinics. Utilize the definition provided on the Report Tool
PCPs - (accepting new members)	Number of PCPs (includes PCPs in clinics) accepting new members
Specialists	All specialists as defined in Section 40.220
Specialists (accepting new members)	Number of Specialists accepting new members
Behavioral Health	All behavioral health providers as defined in Section 40.220
Behavioral Health (accepting new members)	Number of Behavioral Health providers accepting new members
Hospitals	All hospitals
LTSS Facilities (Hosp./NF)	All facilities that have residents receiving LTSS (both hospital-based and free-standing nursing facilities)
Residential Setting (CCFFH, E-ARCH, and ALF)	All residential settings (CCFFH, E-ARCH, and ALF)
HCBS Providers (except residential settings and LTSS facilities)	All other HCBS providers as defined in Section 40.220 excluding those that are residential settings of LTSS facilities
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	All ancillary providers to include pharmacies, laboratories, therapists, hospice, home health agencies.
Total # of providers	Total of all providers listed
	Note: all providers in the QI network should be included. There should be no duplication of provider counts per category. If type is not listed, add provider type to the "Ancillary & Other" section.
Call Center	
# Member Calls	# of calls received from members
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with member	Average time on the phone with member in minutes and seconds
% of member calls abandoned (member hung up)	Percent of member calls abandoned
# Provider Calls	# of calls received from providers
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with provider	Average time on the phone with provider in minutes and seconds
% of provider calls abandoned (provider hung up)	Percent of provider calls abandoned
Medical Claims- Electronic	**Note: (1) A " Processed claim" is a QI claim (not based on # of items/lines in the claim) that "PAID" or "DENIED" in the reporting period. Health plan shall determine how a claim is considered "PAID" or "DENIED". (2) When a single claim that has multiple RECEIVED/PAID/DENIED dates, health plan should use the LAST DATE that the final "PAID" or "DENIED" item/line is made for the 30/90 days calculation because this will be a "completely" processed claim.**
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of electronic claims processed in 30 days
% of claims processed in 90 days	% of electronic claims processed in 90 days
(month to date)	
Medical Claims- Paper	
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month

Item	Description
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of paper claims processed in 30 days
% of claims processed in 90 days	% of paper claims processed in 90 days
(month-to-date)	
Prior Authorization (PA)- Electronic	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month to date)	
Prior Authorization (PA)- Paper and Telephone	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month-to-date)	
# Non-Emergency Transports	
Ground (# of round trips)	# of ground trips for non-emergency transports. A roundtrip is counted as one (i.e., to MD appointment and home is one (1) trip not two (2) trips)
Air (by segment)	# of air trips (by segment) for non-emergency transports i.e. fly from Maui to HNL and back count as 2 segments
Public Transportation Pass (bus pass & handivan coupons)	# of bus passes or handivan coupons issued
# Member Grievances	
# Received	# of member grievances received in the month
# Resolved	# of member grievances resolved in the month
# Outstanding	# of outstanding member grievances at the end of the month Note: The number of member grievances outstanding in this month is the number of member grievances outstanding in the prior month plus the number of member grievances received in this month minus the number of member grievances resolved in this month.
# Provider Grievances	
# Received	# of provider grievances received in the month
# Resolved	# of provider grievances resolved in the month
# Outstanding	# of outstanding provider grievances at the end of the month Note: The number of provider grievances outstanding in this month is the number of provider grievances outstanding in the prior month plus the number of provider grievances received in this month minus the number of provider grievances resolved in this month.
# Member Appeals	
# Received	# of member appeals received in the month
# Resolved	# of member appeals resolved in the month
# Outstanding	# of outstanding member appeals at the end of the month Note: The number of member appeals outstanding in this month is the number of member appeals outstanding in the prior month plus the number of member appeals received in this month minus the number of member appeals resolved in this month.
# Provider Appeals	
# Received	# of provider appeals received in the month
# Resolved	# of provider appeals resolved in the month
# Outstanding	# of outstanding provider appeals at the end of the month Note: The number of provider appeals outstanding in this month is the number of provider appeals outstanding in the prior month plus the number of provider appeals received in this month minus the number of provider appeals resolved in this month.
Utilization - based on Auth (A) or Claims (C)	
Inpatient Acute Admits * (A) - per 1,000	# of inpatient acute admits (based on authorizations) in the month per 1,000 members

Inpatient Acute Days * (A) - per 1,000	# of inpatient acute days (based on authorizations) in the month per 1,000 members
Readmissions within 30 days* (A)	# of readmissions within thirty (30) days in the month based upon authorizations
ED Visits* (C) - per 1,000**	# of ER visits in the previous month (based upon claims) per 1,000. For example, if reporting is on September 15th for August, provide data for July ER visits.
# Prescriptions (C) - per 1,000	# of prescriptions in the month (based upon claims) per 1,000 members
Waitlisted Days* (A) - per 1,000	# of waitlisted days in the month (based upon authorizations) per 1,000 members
NF Admits * (A)	Authorized Non-Medicare nursing facility admissions
# Members in NF (non-Medicare paid days)**(C)	Non-Medicare paid days (claims based)
# Members in HCBS **(C)	# of members in HCBS (excluldes members in at-risk) in the month (based upon claims). Member can be included in more than one category listed below. Note: (1) The listing of HCPCS codes listed on the LTSS Report (Tab D. Auth by Service Code) shall be used to determine those HCPCS codes categorized as 'HCBS' (2) The # of members in HCBS (C) will be based solely on paid claims during the reporting period. This determination will be made irrespective of the member's "1148" status/facility code (e.g. "299")
# Members in Residential Setting **(C)	# of HCBS members in Residential Setting (based upon claims). Note: Based solely on paid claims against HCPCS S5140, T2033 and T2031.
# Members in Self-Direction **(C)	# of HCBS members in Self-Direction (based upon claims)
# Members receiving other HCBS **(C)	# of HCBS members receiving other HCBS servcies (based upon claims) as defined in Section 40.740.3
# Members in At-risk**(C)	# of members in At-risk in the month (based upon claims). Note: The population of At-risk members will be based on a member having an active "at-risk" coded 1147 (i.e. Level of Care Approval Status = 11). Only those with paid claims against HCBS codes noted above shall be included.
# Members in Self-Direction ** (C)	# of At-risk members in Self-Direction in the month (based upon claims)
# Members receiving other HCBS** (C)	# of At-risk members receiving other HCBS services (based upon claims)
	Note: Non-Medicare is for acute, ED, and prescriptions. Health plans should report on acute waitlisted, Medicaid primary NF, and all HCBS (even if these individuals are duals).

(*Non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility
Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.
PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	**26**
Budget Neutrality Reporting End DY	**30**

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 693,404,469	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,546,121	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 464,444,505	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	501,847	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 639,049,304	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	329,548	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 836,728,258	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	316,133	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,633,626,537**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,509,756,770**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 377,340,554	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,526,178,954
EG 2 - Adults	2		$ 166,893,709	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,177,402,903
EG 3 - Aged	3		$ 390,143,173	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,184,112,331
EG 4 – Blind/Disabled	4		$ 482,566,789	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,174,319,337
TOTAL			**$ 1,416,944,225**	**$ 1,647,483,577**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,499,032,410**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 693,404,469	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 377,340,554	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 316,063,915	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 237,047,936	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 464,444,505	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 166,893,709	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 297,550,796	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 223,163,097	$ 206,452,112	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 639,049,304	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 390,143,173	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 248,906,131	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 186,679,599	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 836,728,258	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 482,566,789	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 354,161,470	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 265,621,102	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 912,511,734**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,508,043,270**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 304,170,578**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,502,681,090**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,502,681,090**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,721,114,803	$ 3,647,022,205	$ 5,665,938,359	$ 7,782,532,218	$ 10,001,713,500	
Allowed Cumulative Variance (= CTP X CBNL)			$ 34,422,296	$ 54,705,333	$ 56,659,384	$ 38,912,661	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (304,170,578)	$ (582,594,403)	$ (874,679,416)	$ (1,181,128,664)	$ (1,502,681,090)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,371,657,360	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,525,131	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,371,657,360**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,954,434,233**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$640,892,189	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 640,892,189**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,331,112,116**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 1			**$ 730,765,170**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,623,322,116**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ 364,906	$ 4,695,845	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon	308	3,782	3,877	3,974	4,073	
TOTAL			**$ 364,906**	**$ 4,695,845**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 21,345,851**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ 354,486	$ 4,569,466	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ 354,486**	**$ 4,569,466**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 20,769,176**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 2			**$ 10,420**	**$ 126,379**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 576,675**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ 995,200	$ 12,806,873	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon	308	3,782	3,877	3,974	4,073	
TOTAL			**$ 995,200**	**$ 12,806,873**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 58,215,922**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ 966,780	$ 12,462,181	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ 966,780**	**$ 12,462,181**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 56,643,207**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 3			**$ 28,420**	**$ 344,692**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,572,715**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., “with waiver” expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., “without waiver” expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration’s approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus thoroughout the workbook, including the list of active waivers for the demonstration.

Data Entry	Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

‘Data Pulled On:’ - enter the date the source file used to enter data on this tab was pulled
‘For the Time Period Through :’ - enter the date through which the source file data was pulled
Reporting DY' - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter' - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:
- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration.
From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.
Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.
For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.
For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.
In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.
Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Start Date	8/1/1994	8/1/1995	8/1/1996	8/1/1997	9/1/1998	9/1/1999	9/1/2000	9/1/2001	9/1/2002	9/1/2003	9/1/2004	9/1/2005	9/1/2006	9/1/2007	9/1/2008
End Date	7/31/1995	7/31/1996	7/31/1997	7/31/1998	8/31/1999	8/31/2000	8/31/2001	8/31/2002	8/31/2003	8/31/2004	8/31/2005	8/31/2006	8/31/2007	8/31/2008	8/31/2009

DY	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Start Date	9/1/2009	9/1/2010	9/1/2011	9/1/2012	10/1/2013	1/1/2014	1/1/2015	1/1/2016	1/1/2017	1/1/2018	8/1/2019	8/1/2020	8/1/2021	8/1/2022	8/1/2023
End Date	8/31/2010	8/31/2011	8/31/2012	8/31/2013	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	7/31/2019	7/31/2020	7/31/2021	7/31/2022	7/31/2023	7/31/2024

Enter any general comments / notes:

MEG Definitions

	MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
	Medicaid Per Capita								
1	EG 1 - Children		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
2	EG 2 - Adults		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
3	EG 3 - Aged		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
4	EG 4 – Blind/Disabled	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
					N/A				
	Medicaid Per Capita - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Hypothetical 1 Per Capita				Hypothetical Test 1				
1	EG 5 – Group VIII	Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act	N/A	No	Yes	*20*	*10/1/2013*	*20*	*12/31/2013*
			N/A						
			N/A						
	Hypothetical 1 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 2 Per Capita				Hypothetical Test 2				
1	EG 6 - CIS	Expenditures related to the CIS benefits of pre-tenancy supports and tenancy supports; excludes expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 2 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 3 Per Capita				Hypothetical Test 3				
1	EG 7 – CIS Community Transition Pilot	Expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 3 Aggregate								
			N/A						
			N/A						
			N/A						
	Tracking Only								

WOW PMPMs and Aggregates

Medicaid Per Capita		26	27	28	29	30
EG 1 - Children	1	$448.48	$452.96	$457.49	$462.07	$466.69
EG 2 - Adults	2	$925.47	$959.72	$995.23	$1,032.05	$1,070.24
EG 3 - Aged	3	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66
EG 4 – Blind/Disabled	4	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25

Hypothetical 1 Per Capita		26	27	28	29	30
EG 5 – Group VIII	1	$899.37	$942.54	$987.78	$1,035.20	$1,084.89

Hypothetical 2 Per Capita		26	27	28	29	30
EG 6 - CIS	1	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15

Hypothetical 3 Per Capita		26	27	28	29	30
EG 7 – CIS Community Transition Pilot	1	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67

Program Spending Limits

						TOTAL
Program Name and Associated MEGs	**26**	**27**	**28**	**29**	**30**	
Spending Cap						
						$ -
Expenditures Subject to Cap						
Variance						$ -
Over or Under	.	.	.	.	.	.

Date Pulled On:	8/10/2020	Reporting DY	26
For the Time Period Through:	6/30/2020	Reporting Quarter	4

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.
1. On the Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two rounds of copy/paste starting from the cell in column A (Waiver Name).
· MAP Waivers/ Total Computable section – into cell A100
· MAP Waivers/ Federal Share section – into cell A200
3. If ADM waivers are applicable to the demonstration, complete two more rounds of copy/paste starting from the cell in column A (Waiver Name).
· ADM Waivers/ Total Computable section – cell A300
· ADM Waivers/ Federal Share section – cell A400

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	70,981,761	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,981,761	70,981,761
1902 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(8,243,749)	(8,243,749)
1902R2	0	121,392	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	121,392	121,392
AFDC	0	148,069,654	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	148,069,654	148,069,654
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(295)	121,279,464	314,952,648	350,714,627	326,518,117	349,156,948	184,750,729	364,919,444	307,865,937	320,856,325	334,461,311	556,397,282	332,660,935	0	0	0	0	3,864,533,472	3,864,533,472
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,424,989	17,555,107	24,914,002	19,728,957	24,483,589	14,925,306	37,994,811	48,712,106	46,535,285	56,077,526	84,369,050	58,158,028	0	0	0	0	435,878,756	435,878,756
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(473,188)	(505,165)	(397,775)	(598,936)	(246,664)	0	0	0	0	(2,221,728)	(2,221,728)
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(14,668)	(44,822)	(62,495)	(43,976)	(15,029)	0	0	0	0	(180,990)	(180,990)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(13,736)	31,794,652	74,760,519	81,089,359	77,504,607	88,201,319	49,105,356	98,847,286	163,362,887	158,584,686	156,543,760	245,289,171	134,716,295	0	0	0	0	1,359,786,161	1,359,786,161
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(28,991)	81,514,842	211,664,665	248,689,322	257,028,809	282,670,355	148,440,400	290,201,067	285,336,958	310,399,367	343,436,931	473,194,759	311,124,033	0	0	0	0	3,243,672,517	3,243,672,517
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(324,738)	(333,645)	(370,635)	(399,762)	(154,781)	0	0	0	0	(1,583,561)	(1,583,561)
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(61,110)	(74,223)	(153,925)	(230,511)	(47,017)	0	0	0	0	(566,786)	(566,786)
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	4,053	545,332	904,018	750,145	365,104	585,589	277,616	222,869	103,847	107,831	72,021	0	0	0	0	3,938,423	3,938,423
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	730,733,483	730,733,483
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	272,778,438	272,778,438
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40,064,795	40,064,795
Demo Elig Adults	0	0	0	0	0	0	0	0	134,638	1,995	51,709	318,560	127,982,800	129,456,848	154,209,257	177,392,619	201,628,981	238,945,778	244,752,500	227,394,155	43,950,943	55,913	(5,724)	735	0	0	0	0	0	0	0	1,546,271,707	1,546,271,707
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	191,925,290	343,770,506	477,529,767	546,346,803	785,221,044	482,070,857	0	0	0	0	2,826,864,267	2,826,864,267
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	91,499	83,366	94,158	137,403	73,022	176,324	173,482	703,614	618,274	885,664	1,318,600	2,269,310	1,533,181	0	0	0	0	8,157,897	8,157,897
Hawaii Quest-1902(R)(2)	0	700,529	107,270	2,484,576	1,636,854	860,335	1,594,466	0	0	284	34,836	438,582	0	0	33,061	26,332	8,001	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,925,126	7,925,126
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135,520	683,159	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	818,679	818,679
HealthQuest-Current	0	3,884,748	350,430	12,121,771	10,002,019	7,377,643	10,651,130	9,373,702	64,428,704	230,593,470	268,955,153	392,471,288	(2,325,152)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,007,884,906	1,007,884,906
HealthQuest-Others	0	1,783,163	215,685	5,322,833	3,698,445	2,678,918	3,915,013	3,306,673	21,010,550	63,645,959	99,234,046	93,729,117	(621,643)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	297,918,759	297,918,759
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	56,504	120,767	115,693	58,345	117,005	109,837	8,305	0	0	0	0	0	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,715	3,960	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	122,839	581,513	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,050,612	165,286,471	110,172,746	129,011,135	187,835,164	105,413,650	0	0	0	0	914,771,109	914,771,109
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,100,418	16,199,737	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	76,678	103,084	80,075	257,166	253,182	31	0	0	0	0	0	0	0	0	0	0	0	0	0	770,216	770,216
OTHERS	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	376,237,032	376,237,032
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	0	(15,309,727)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(15,309,727)	(15,309,727)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(2,751)	798,681	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205	76,432,838	26,173,447	106,232	0	0	0	0	0	0	0	0	0	205,854,785	205,854,785
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862,479	17,432,949	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,990	2,628,840	2,628,927	2,873,646	987,921	1,532,329	1,448,764	2,048,646	2,315,023	4,043,498	2,757,699	0	0	0	0	23,290,283	23,290,283
State Plan Adults	0	0	0	0	0	0	0	0	(10)	218	99	39,158	111,982,730	118,021,622	109,034,691	128,225,118	131,863,143	123,596,289	112,790,909	130,112,852	80,834,554	202,368,440	172,913,238	169,100,872	182,763,865	252,875,467	150,156,180	0	0	0	0	2,176,679,435	2,176,679,435
State Plan Children	0	0	0	0	0	0	0	(41)	(9,403)	2,008	878	2,541,467	181,803,051	179,672,723	155,392,585	168,853,209	202,959,370	213,968,923	187,874,968	215,942,758	106,595,650	248,572,791	306,184,516	316,781,980	372,274,084	582,900,600	344,362,327	0	0	0	0	3,786,674,444	3,786,674,444
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	7,500,002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,500,002	7,500,002
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	17,822,210	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	15,688,221	22,546,108	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842	12,164,879	5,856,911	10,090,466	6,184,588	981,179	0	0	0	0	0	0	0	216,220,054	216,220,054
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	609,561	0	0	0	0	0	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	10,056,500	3,403,710	7,500,000	7,500,000	7,500,000	7,500,000	0	38,818,619	39,694,442	82,153,936	85,515,739	66,000,000	0	0	0	0	0	0	0	355,642,946	355,642,946
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	71,468,225	(8,863)	0	0	0	0	0	0	0	0	0	71,459,362	71,459,362
Total	0	1,430,419,192	673,385	19,929,180	15,337,318	10,916,896	18,580,159	228,727,963	244,800,211	294,243,934	368,276,721	514,860,384	444,696,938	454,123,543	464,250,373	785,020,500	1,211,765,023	1,357,369,890	1,307,250,747	1,449,178,427	773,323,801	1,747,098,957	1,886,598,172	1,979,142,266	2,123,668,055	3,173,229,991	1,922,561,715	0	0	0	0	24,226,043,741	24,226,043,741

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	35,490,882	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35,490,882	35,490,882
1902 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	60,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	0	74,034,827	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74,034,827	74,034,827
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(199)	81,134,508	211,362,743	229,319,379	165,433,841	179,767,116	95,671,244	189,594,082	162,182,080	173,947,428	183,569,362	302,216,598	189,574,319	0	0	0	0	2,163,772,501	2,163,772,501
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,622,988	11,822,762	16,022,396	9,984,628	12,621,590	7,728,650	19,714,969	25,630,796	25,194,791	30,741,179	45,680,729	33,260,458	0	0	0	0	240,025,936	240,025,936
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(249,679)	(273,613)	(218,333)	(324,766)	(132,314)	0	0	0	0	(1,198,705)	(1,198,705)
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,720)	(24,377)	(34,310)	(23,817)	(8,065)	0	0	0	0	(98,289)	(98,289)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(9,251)	21,277,328	49,857,636	52,547,252	39,129,038	45,400,574	25,392,157	51,341,230	86,036,126	85,942,520	85,900,152	133,232,597	76,721,800	0	0	0	0	752,769,159	752,769,159
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(19,525)	54,511,233	141,799,152	161,274,589	130,207,936	145,622,789	76,872,883	150,336,282	149,646,906	167,640,879	188,068,224	255,415,356	177,520,828	0	0	0	0	1,798,897,532	1,798,897,532
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(171,495)	(180,813)	(203,447)	(216,481)	(83,070)	0	0	0	0	(855,306)	(855,306)
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(32,236)	(40,358)	(84,504)	(125,175)	(25,238)	0	0	0	0	(307,511)	(307,511)
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1)	2,754	361,286	592,247	495,478	241,945	376,275	201,477	152,695	77,771	62,621	49,463	0	0	0	0	2,614,011	2,614,011
CURRENT	0	247,684,665	0	0	0	0	904,176	83,526,544	40,668,142	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	372,783,527	372,783,527
CURRENT POP	0	136,389,220	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	136,389,220	136,389,220
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	0	0	0	0	0	0	0	0	79,127	1,144	30,236	186,922	75,196,276	74,766,107	87,642,204	114,378,784	135,452,513	154,819,222	123,131,091	116,746,726	22,522,276	29,051	(3,183)	397	0	0	0	0	0	0	0	904,978,893	904,978,893
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	157,575,707	316,674,622	458,127,934	506,770,253	729,396,521	439,734,171	0	0	0	0	2,608,279,208	2,608,279,208
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51,916	53,413	63,415	89,013	36,291	90,804	89,632	365,633	326,044	480,663	723,548	1,231,959	873,444	0	0	0	0	4,475,775	4,475,775
Hawaii Quest-1902(R)(2)	0	353,988	53,702	1,242,907	818,930	430,573	808,769	0	0	166	20,369	256,468	0	0	18,679	19,755	5,389	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76,578	438,797	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	1,963,002	175,736	6,063,866	5,004,058	3,692,366	5,386,340	4,903,637	36,087,606	132,768,282	165,985,082	231,578,381	(1,365,848)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	901,053	107,974	2,662,739	1,849,641	1,340,727	1,981,352	1,733,011	11,768,154	36,642,802	60,584,431	55,313,761	(363,962)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	32,497	68,553	68,082	38,985	78,049	64,590	4,238	0	0	0	0	0	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,196	2,666	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69,404	368,050	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,032,614	165,286,235	110,132,233	122,602,921	175,831,129	96,186,968	0	0	0	0	887,073,431	887,073,431
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,881,647	10,235,011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	44,819	59,404	45,487	166,217	170,408	21	0	0	0	0	0	0	0	0	0	0	0	0	0	486,356	486,356
OTHERS	0	144,525,295	0	0	0	0	426,612	29,580,209	16,428,385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	190,960,501	190,960,501
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	0	(7,809,492)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,809,492)	(7,809,492)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(1,583)	454,606	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685	39,331,445	13,397,540	55,183	0	0	0	0	0	0	0	0	0	115,390,826	115,390,826
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,442,944	10,922,768	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,829	1,707,938	1,317,977	1,473,988	508,843	795,526	764,288	1,111,786	1,270,634	2,194,658	1,572,392	0	0	0	0	12,734,859	12,734,859
State Plan Adults	0	0	0	0	0	0	0	0	(6)	125	52	22,986	65,812,117	68,288,552	61,892,816	82,540,889	88,651,957	80,730,594	56,365,779	66,741,085	41,647,599	104,845,589	90,882,653	91,248,915	100,173,554	136,932,234	85,631,834	0	0	0	0	1,222,409,324	1,222,409,324
State Plan Children	0	0	0	0	0	0	0	(23)	(5,530)	1,173	507	1,494,521	106,725,591	103,797,242	88,086,005	108,850,847	136,539,237	138,140,612	92,677,457	110,463,464	54,513,194	128,939,345	161,395,719	171,639,115	204,203,750	316,303,071	196,424,485	0	0	0	0	2,120,189,782	2,120,189,782
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	4,385,251	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,385,251	4,385,251
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	10,614,749	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	9,212,484	13,041,165	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917	6,249,536	3,037,111	5,240,639	3,261,810	529,641	0	0	0	0	0	0	0	125,000,399	125,000,399
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	307,706	0	0	0	0	0	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	5,787,516	1,958,835	4,237,500	4,959,750	5,051,250	4,697,250	0	20,131,336	20,583,506	42,677,271	45,049,870	35,626,800	0	0	0	0	0	0	0	190,760,884	190,760,884
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37,060,184	(4,595)	0	0	0	0	0	0	0	0	0	37,055,589	37,055,589
Total	0	716,158,823	337,412	9,969,512	7,672,629	5,463,666	9,493,195	119,743,378	135,002,643	169,413,692	226,620,677	303,853,039	261,079,907	262,434,464	263,479,344	510,938,536	813,433,104	881,694,769	657,883,831	745,135,931	399,268,095	1,068,914,801	1,206,874,313	1,321,256,636	1,423,560,754	2,097,807,234	1,297,301,475	0	0	0	0	14,914,791,860	14,914,791,860

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	63,695,860	0	0	0	0	1,013,990,557	1,013,990,557
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214	12,833,291	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	40,068,477	45,961,643	56,826,439	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	63,695,860	0	0	0	0	1,061,954,810	1,061,954,810

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	43,209,415	0	0	0	0	699,548,945	699,548,945
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187	6,534,554	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	21,285,217	23,906,078	31,788,472	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	43,209,415	0	0	0	0	724,245,560	724,245,560

C Report Grouper

MAP Waivers Only

Total Computable

MEG Names		**C Report Waiver Names**	**26**	**27**	**28**	**29**	**30**
Medicaid Per Capita							
EG 1 - Children	1	FosterCare(19-20)	$1,533,181				
EG 1 - Children	1	State Plan Children	$344,362,327				
EG 2 - Adults	2	State Plan Adults	$150,156,180				
EG 2 - Adults	2	Breast Cervical Cancer Treatment (BCCT)	$72,021				
EG 2 - Adults	2	St Pl Adults-Preg Immig/COFAs	$2,757,699				
EG 3 - Aged	3	Aged w/Mcare	$332,660,935				
EG 3 - Aged	3	Aged w/o Mcare	$58,158,028				
EG 3 - Aged	3	Aged with Medicare - MFP	($246,664)				
EG 3 - Aged	3	Aged without Medicare - MFP	($15,029)				
EG 4 – Blind/Disabled	4	B/D w/Mcare	$134,716,295				
EG 4 – Blind/Disabled	4	B/D w/o Mcare	$311,124,033				
EG 4 – Blind/Disabled	4	Blind/Disable without Medicare - MFP	($154,781)				
EG 4 – Blind/Disabled	4	Blind/Disabled with Medicare - MFP	($47,017)				
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1	VIII-Like Group					
EG 5 – Group VIII	1	Expansion State Adults	$482,070,857				
EG 5 – Group VIII	1	Newly Eligible Adults	$105,413,650				
Hypothetical 2 Per Capita							
EG 6 - CIS	1	EG 6 - CIS					
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1	EG 7 – CIS Community Transition Pilot					
TOTAL			$1,922,561,715				

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.
Positive adjustments increase expenditures, and negative adjustments decrease expenditures.
Enter adjustments for every MEG for which adjustments were made or are planned.
Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -$10,000 reflects a decrease in expenditures).

		26	27	28	29	30	Description (type of collection, time period, CMS-64 reporting line, etc.)
Medicaid Per Capita							
EG 1 - Children	1						
EG 2 - Adults	2						
EG 3 - Aged	3	-$32,926,028					Cost share
EG 4 – Blind/Disabled	4	-$3,285,640					Cost share
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1						
Hypothetical 2 Per Capita							
EG 6 - CIS	1						
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1						

WW Spending - Actual

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$345,895,508				
EG 2 - Adults	2	$152,985,900				
EG 3 - Aged	3	$357,631,242				
EG 4 – Blind/Disabled	4	$442,352,890				
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$587,484,507				
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					
TOTAL		**$ 1,886,350,047**	**$ -**	**$ -**	**$ -**	**$ -**

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.
Enter the projected annual expenditures for each DY per MEG for the active DYs.
For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$31,445,046	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$13,907,809	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$32,511,931	$441,394,654	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$40,213,899	$584,531,853	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$53,407,682	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1	$354,486	$4,569,466	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1	$966,780	$12,462,181	$13,386,875	$14,380,181	$15,447,190

WW Spending - Total

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$377,340,554	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$166,893,709	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$390,143,173	$441,394,654	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$482,566,789	$584,531,853	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$640,892,189	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1	$354,486	$4,569,466	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1	$966,780	$12,462,181	$13,386,875	$14,380,181	$15,447,190
TOTAL		**$ 2,059,157,680**	**$ 2,490,505,522**	**$ 2,632,405,315**	**$ 2,782,912,389**	**$ 2,942,576,003**

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.
For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.
Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.
Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1276716				
EG 2 - Adults	2	379952				
EG 3 - Aged	3	309610				
EG 4 – Blind/Disabled	4	260755				
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1272111				
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					

Member Months - Projected

Enter/adjust projected member months based on reported actuals.
Enter projected number of member months for each active DY per MEG for the demonstration.
For the current DY, enter only the number that reflects projections for future quarters of the DY.
Do not include member months for either the current reporting quarter or past quarters.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	269405	1584774	1624394	1665004	1706629
EG 2 - Adults	2	121895	514393	527253	540435	553945
EG 3 - Aged	3	19938	332843	336172	339533	342929
EG 4 – Blind/Disabled	4	55378	319294	322487	325712	328969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	253020	1563260	1602341	1642400	1683460
Hypothetical 2 Per Capita						
EG 6 - CIS	1	308	3782	3877	3974	4073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1	308	3782	3877	3974	4073

Member Months - Total

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1,546,121	1,584,774	1,624,394	1,665,004	1,706,629
EG 2 - Adults	2	501,847	514,393	527,253	540,435	553,945
EG 3 - Aged	3	329,548	332,843	336,172	339,533	342,929
EG 4 – Blind/Disabled	4	316,133	319,294	322,487	325,712	328,969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1,525,131	1,563,260	1,602,341	1,642,400	1,683,460
Hypothetical 2 Per Capita						
EG 6 - CIS	1	308	3,782	3,877	3,974	4,073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1	308	3,782	3,877	3,974	4,073

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	26
Budget Neutrality Reporting End DY	30

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 693,404,469	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,546,121	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 464,444,505	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	501,847	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 639,049,304	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	329,548	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 836,728,258	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	316,133	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,633,626,537**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,509,756,770**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 377,340,554	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,526,178,954
EG 2 - Adults	2		$ 166,893,709	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,177,402,903
EG 3 - Aged	3		$ 390,143,173	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,184,112,331
EG 4 – Blind/Disabled	4		$ 482,566,789	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,174,319,337
TOTAL			**$ 1,416,944,225**	**$ 1,647,483,577**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,499,032,410**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 693,404,469	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 377,340,554	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 316,063,915	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 237,047,936	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 464,444,505	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 166,893,709	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 297,550,796	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 223,163,097	$ 206,452,112	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 639,049,304	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 390,143,173	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 248,906,131	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 186,679,599	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 836,728,258	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 482,566,789	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 354,161,470	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 265,621,102	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 912,511,734**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,508,043,270**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 304,170,578**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,502,681,090**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,502,681,090**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,721,114,803	$ 3,647,022,205	$ 5,665,938,359	$ 7,782,532,218	$ 10,001,713,500	
Allowed Cumulative Variance (= CTP X CBNL)			$ 34,422,296	$ 54,705,333	$ 56,659,384	$ 38,912,661	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (304,170,578)	$ (582,594,403)	$ (874,679,416)	$ (1,181,128,664)	$ (1,502,681,090)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,371,657,360	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,525,131	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,371,657,360**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,954,434,233**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$640,892,189	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 640,892,189**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,331,112,116**
HYPOTHETICALS VARIANCE 1			**$ 730,765,170**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,623,322,116**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ 364,906	$ 4,695,845	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon	308	3,782	3,877	3,974	4,073	
TOTAL			**$ 364,906**	**$ 4,695,845**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 21,345,851**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ 354,486	$ 4,569,466	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ 354,486**	**$ 4,569,466**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 20,769,176**
HYPOTHETICALS VARIANCE 2			**$ 10,420**	**$ 126,379**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 576,675**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ 995,200	$ 12,806,873	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon	308	3,782	3,877	3,974	4,073	
TOTAL			**$ 995,200**	**$ 12,806,873**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 58,215,922**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ 966,780	$ 12,462,181	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ 966,780**	**$ 12,462,181**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 56,643,207**
HYPOTHETICALS VARIANCE 3			**$ 28,420**	**$ 344,692**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,572,715**

Yes No
Yes
No

Per Capita or Aggregate
Per Capita
Aggregate

Phase-Down
No Phase-Down
Savings Phase-Down

Actuals and Projected
Actuals Only
Actuals + Projected

MAP_ADM
MAP+ADM Waivers
MAP Waivers Only

Waiver List
MAP WAIVERS
Not Applicable
1,115
1902 R 2
1902 R 2X
1902R2
AFDC
Aged w/Mcare
Aged w/o Mcare
Aged with Medicare - MFP
Aged without Medicare - MFP
B/D w/Mcare
B/D w/o Mcare
Blind/Disable without Medicare - MFP
Blind/Disabled with Medicare - MFP
Breast Cervical Cancer Treatment (BCCT)
CURRENT
CURRENT POP
Current-Hawaii Quest
Demo Elig Adults
EG 6 - CIS
EG 7 – CIS Community Transition Pilot
Expansion State Adults
FosterCare(19-20)
HawaiiQuest-1902(R)(2)
HCCP
HealthQuest-Current
HealthQuest-Others
Med Needy Adults
Med Needy Children
MFCP
Newly Eligible Adults
NH w/o W
Opt St Pl Children
Others
Others-Hawaii Quest
OthersX
QUEST ACE
RAACP
St PI Adults-Preg Immig/COFAs
State Plan Adults
State Plan Children
Supp. - Private
Supp. - State Gov.
UCC-Governmental
UCC-GOVT LTC
UCC-Private
VIII-Like Group
ADM WAIVERS

Demonstration Reporting Start DY	26
Demonstration Reporting End DY	30

Reporting Net Variance
$ 1,502,681,090