Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: September 2, 2015

Demonstration/Quarter Reporting Period:
Demonstration Year: 21 (4/1/2015-6/30/2015)
Federal Fiscal Quarter: 3/2015 (4/1/2015-6/30/2015)
State Fiscal Quarter: 4/2015 (4/1/2015-6/30/2015)
Calendar Year: 2/2015 (4/1/2015-6/30/2015)

Introduction

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

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

The State's goals in the demonstration are to:

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

Enrollment Information

Note: Enrollment counts include both person counts (unduplicated members) and member months. Member months and unduplicated members data for April 2015 to June 2015.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 4/2015-6/2015	Unduplicated Members 4/2015-6/2015
Mandatory State Plan Groups			
State Plan Children	State Plan Children	352,718	116,224
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	128,406	43,462
Aged	Aged w/Medicare Aged w/o Medicare	71,760	26,184
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	73,213	25,666
Expansion State Adults	Expansion State Adults	189,891	62,215
Newly Eligible Adults	Newly Eligible Adults	104,031	35,622
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,157	422
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults	-16	14
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group	-32	36
Total		921,128	309,845

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	212,008
Title XXI funded State Plan	29,457
Title XIX funded Expansion	97,837
Enrollment current as of	6/30/2015

Outreach/Innovative Activities

The DHS focused on enrolling Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria. In addition, MQD fine-tuned its work within its eligibility system called Kauwale (community) On-Line Eligibility Assistance System (KOLEA). DHS focused applicants to apply on-

line at its mybenefits.hawaii.gov website.

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

Operational/Policy Developments/Issues

During the third quarter of FFY15, the Med-QUEST Division (MQD) continued its monitoring of the QUEST Integration (QI) implementation that occurred in the second quarter of FFY15. QUEST Integration or QI is a melding of both the QUEST and QExA programs. QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition. In QUEST Integration, health plans will provide a full-range of comprehensive benefits including long-term services and supports. MQD has lowered its ratios for service coordination.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ‘Ohana Health Plan, and UnitedHealthcare Community Plan. The MQD has been assuring readiness of the five (5) QI health plans since February of 2014 (see transition information later in the report).

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for third quarter of FFY15 will be submitted in the future.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (April 2015)	Month 2 (May 2015)	Month 3 (June 2015)	Total for Quarter Ending 6/2015
EG 1-Children	116,195	117,763	119,917	353,875
EG 2-Adults	43,116	42,950	42,324	128,390
EG 3-Aged	23,127	24,355	24,278	71,760
EG 4-Blind/Disabled	24,004	24,579	24,630	73,213
EG 5-VIII-Like Adults	-29	-11	8	-32
EG 6-VIII Group Combined	95,655	98,340	99,927	293,922

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (April 2015)	Month 2 (May 2015)	Month 3 (June 2015)	Total for Quarter Ending 6/2015
State Plan Children	115,821	117,371	119,526	352,718
State Plan Adults	43,135	42,947	42,324	128,406
Aged	23,127	24,355	24,278	71,760

With Waiver Eligibility Group	Month 1 (April 2015)	Month 2 (May 2015)	Month 3 (June 2015)	Total for Quarter Ending 6/2015
Blind or Disabled	24,004	24,579	24,630	73,213
Expansion State Adults	60,886	63,621	65,384	189,891
Newly Eligible Adults	34,769	34,719	34,543	104,031
Optional State Plan Children				
Foster Care Children, 19-20 years old	374	392	391	1,157
Medically Needy Adults				
Demonstration Eligible Adults	-19	3	0	-16
Demonstration Eligible Children				
VIII-Like Group	-29	-11	8	-32

QUEST Integration Consumer Issues

HCSB Grievance

During the third quarter of FFY15, the HCSB continued to handle incoming calls. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (QUEST Integration or QI), transfer those telephone calls to the HCSB. The clerical staff person(s) takes the basic contact information and assigns the call to one of the social workers. MQD tracks all of the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., request to change health plan), then the CSB will work with the client to resolve their issue. The CSB did not have any calls related to QI this quarter.

	Member		Provider	
	QI	FFS	QI	FFS
April 2015	15	2	7	10
May 2015	10	6	5	15
June 2015	13	2	2	7
Total	38	10	14	22

During the third quarter of FFY15, the HCSB staff, as well as other MQD staff, processed approximately 84 member and provider telephone calls and e-mails (see table above). The number of calls from members higher than other quarters. In previous quarters, MQD received approximately 55 to 60 calls, letters, and e-mails. The anticipated increase is due to education of members in the third quarter of FFY15 related to filing grievances and appeals (all members were sent a handout describing this benefit).

HCSB Appeals

The HCSB received four (4) member appeals in the third quarter of FFY15. DHS resolved two of the appeals with the health plans in the member's favor prior to going to hearing. One (1) appeal was resolved in DHS' favor. One (1) DHS is still awaiting the results.
Of the four (4) appeals filed, the types of appeals were medical (1), LTSS (2), and medication (1).

Appeals	Member #
Submitted	4
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	2
Member withdrew hearing request	0
Resolution in DHS favor	1
Resolution in Member's favor	0
Still awaiting resolution	1

Types of Member Appeals	#
Medical	1
LTSS	2
Other: Medications	1

Provider Interaction
The MQD and the health plans continue to have two regularly scheduled meetings with providers. One of the meetings is a monthly meeting with the Case Management Agencies. MQD focuses the meetings with these agencies around continually improving and modifying processes within the health plans related to HCBS. In addition, the MQD and health plans meet with the behavioral health provider group that serves the CCS population. This group focuses on health plan systems and addressing needs of this fragile population.

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

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

Enrollment of individuals

The DHS had an increase of enrollment of approximately 11,397 members during the third quarter of FFY15. Of this group, 194 chose their health plan when they became eligible, 3,281 changed their health plan after being auto-assigned.

	#
Individuals who chose a health plan when they became eligible	194
Individuals who changed their health plan after being auto-assigned	3,281
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	151
Individuals in the ABD program	16

In addition, DHS had 151 plan-to-plan changes during the third quarter of FFY15. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 16 individuals in the aged, blind, and

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

that changed their health plan within days 61 to 90 after confirmation notice was issued	

Long-Term Services and Supports (LTSS)

HCBS Waiting List

During the third quarter of FFY15, the QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the third quarter of FFY15, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring long-term services and supports continues to increase. In the third quarter of FFY15, the increase is 38.6% since the start of the program receiving long-term services and supports. The number of individuals in nursing facilities increased this past quarter. HCBS usage has more than doubled since the start of the bringing the aged, blind, and disabled population into managed care (formerly QUEST Expanded Access (QExA), currently QUEST Integration). Nursing facility services have decreased by approximately 18.5% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 116% since program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving long-term care services. This number has increased to 66% (66.3%) since the start of the program.

	2/1/09	2nd Qtr FFY15, av	3rd Qtr FFY15, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 3rd Qtr FFY15
HCBS	2,110	4,660	4,548	115.5%↑	42.6%	66.3%↑
NF	2,840	2,412	2,314	18.5%↓	57.4%	33.7%↓
Total	4,950	7,072	6,862	38.6%↑		

Behavioral Health Programs Administered by the DOH and DHS

Individuals in Community Care Services (CCS) have a Serious Mental Illness (SMI) diagnosis with functional impairment. The Medicaid beneficiaries who continue to receive services from AMHD are legally encumbered. These individuals are under court order to be cared for by AMHD.

Program	#
Adult Mental Health Division (AMHD/DOH)	223
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,201
Community Care Services (CCS/DHS)	5,693

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). CAMHD is providing services to approximately 1,200 children during the third quarter to FFY15.

QUEST Integration transition

The MQD moved all of its QUEST and QExA population into the QUEST Integration (QI) program on January 1, 2015. The transition was seamless with all five-health plans being ready to accept their new members. All five health plans received transition of care files in November and December 2014 that allowed them to maintain services through March 31, 2015 (or until a new health and functional assessment (HFA) was conducted). In addition, several health plans maintained services to June 30, 2015 while they completed their HFAs.

The MQD continued to conduct three additional oversight processes. Information about these programs is included below.

1. **Ride along program**
   MQD nurses and socials workers went on home visits with service coordinators to observe their conducting assessments and developing service plans. These ride alongs identified areas for improvement to include pre-filling assessments prior to the visit, talking with member to obtain information instead of reading the questions from the assessment tool, and listening to needs of the member more than paying attention to questions on the assessment tool. MQD shared these observations with health plan leadership in April 2015.

2. **Customer Service Call Listen-In program**
   MQD staff listed to live health plan QUEST Integration customer service calls to ensure that customer service representatives were meeting MQD contract requirements. Initially, all five health plans had room for improvement. After providing health plans with a summary of the listen-in program, all five health plans are performing at 100%. MQD continues to listen to calls to support our beneficiaries.

3. **Review of all reductions of home and community based services**
   Health plans submitted all reductions of HCBS services to MQD for review weekly. MQD did not see any indication of health plans reducing HCBS incorrectly.

Quality Assurance/Monitoring Activity

MQD Quality Strategy

Our goal continues to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. We have adopted the Institute of Medicine’s framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. MQD identified an initial set of ambulatory care measures based on this framework. MQD reviews and updates HEDIS measures annually that the health plans report to us.

MQD continues to update its quality oversight of home and community based services, which will affect mostly our QI health plans, the DDID program, and the Going Home Plus program. MQD uses quality grid based upon the HCSB Quality Framework for monitoring the DDID program. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also been working on behavioral health monitoring and quality improvement.

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

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD is waiting feedback from CMS prior to implementing. The revised quality strategy is consistent with the previously approved 2010 version.

Quality Activities during the quarter
The following is a description of the EQRO activities completed for this quarter. The EQRO performs oversight of health plans for the QI and Community Care Services (CCS) programs:

The following is a description of the External Quality Review Organization (EQRO) activities completed for this quarter. The EQRO performs oversight of health plans for the QI and Community Care Services (CCS) programs. The Health Services Advisory Group (HSAG) did the following:

1. Validation of Performance Improvement Projects (PIPS) –
   - Presented Module 3: Intervention Determination specific training (Process Mapping, Failure Modes and Effects Analysis, Failure Mode Ranking and Change Concepts) to the MQD and health plans at the end of May.
   - Module 3 submissions were due at the start of July.
   - Reviewed resubmissions of Modules 1 and 2 and provided feedback and technical assistance to the health plans.
   - All health plans passed Modules 1 and 2.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –
   - Worked with health plans to complete follow-up items requested in the Information Systems (IS) Tracking Grids.
   - All medical record review activities completed and medical record review validation (MRRV) results provided to the health plans.
   - All follow-up items resolved and health plans submitted final rates with Managed Care Organization (MCO) lock applied to Interactive Data Submission System (IDSS) submissions by 6/8/15.
   - Health plans submitted signed HEDIS Roadmap Attestation upon approval from the lead auditor and prior to completion of final rate review.
   - Final rate review completed by 6/15/15 (auditor lock applied to IDSS submissions; health plans marked final, completing the IDSS submission process).
   - HSAG developed a macro that will lock the entire workbook so that no revisions can be made, alleviating the MQD's concerns regarding changes. The MQD approved this method.

3. Compliance Monitoring –
   - On 5/6/15, provided one of the health plans and the MQD with the final 2015 compliance review report and a template for this health plan to complete its corrective action plan (CAP). The CAP was due on or before 6/8/15.
   - Received and coordinated with the MQD on the evaluation of sufficiency of the health plan's CAP from its 2015 compliance review. Following revision and resubmission of the CAP, the health plan received approval of the CAP on 6/15/15.
   - On 6/30/15, the health plan uploaded its 2015 CAP implementation documentation for review.
   - Corresponded with the MQD regarding status of CAP actions and approvals of CAP documents for some of the other health plans.

- Updated the health plans' 2014 compliance review CAP reports, received approval from the MQD, and sent the request for CAP status updates from each of the plans on 5/29/15. CAP status reports were due from the plans on or before 6/30/15.
- Received 2014 CAP status updates from the other health plans as requested.
- Assisted the MQD with review of documents and feedback to the plans on remaining findings from the 2014 compliance reviews. These documents centered on the plans' credentialing and contracting processes and capture/reporting of provider disclosure information (42 CFR 455).

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   - Submitted weekly disposition reports to the MQD in April 2015.
   - Mailed third postcard reminders to non-respondents and refreshed phone number files prior to Computer Assisted Telephone Interviewing (CATI) using Telematch in April.
   - Performed CATI monitoring of survey vendor on 4/20/15.
   - Extended the timeline for the survey fielding to 5/6/15 in order to allow for additional time to perform telephone follow-up of non-respondents. (This extension did not impact the timeline for submission of deliverables to the MQD.)
   - Completed CATI for non-respondents and notified the MQD survey field closed on 5/6/15.
   - Received data files from subcontractor on 5/18/15.
   - Began reconciliation of raw survey data.
   - Completed submission of Medicaid survey data to National Committee for Quality Assurance (NCQA) for all health plans at end of May.
   - Submitted final, reconciled disposition report to the MQD and notified the MQD that submission of the health plans' CAHPS data to NCQA was completed on 6/1/15.
   - MQD completed National CAHPS Benchmarking Database (NCBD) account reactivation process and provided HSAG with vendor account access by 6/5/15.
   - Notified the MQD on 6/15/15 that submission of data to NCBD for the health plans and CHIP was completed.
   - Began survey data analysis for production of Star Reports and preparation of member-level raw survey data files for submission to the MQD.

5. Provider Survey –
   - Participated in call with the MQD on 4/2/15, to discuss possible solutions for provider email addresses not being available on sample frame file.
   - Received the MQD's final approval of the reformatted survey instrument and received the MQD's final approval of the revised cover letters in the beginning of April.
   - Submitted the revised provider notification document and revised project timeline to the MQD for review on 4/6/15. Revised project timeline approved by MQD on 4/8/15.
   - Received the health plans' sample frame file crosswalks of provider IDs and available email addresses from the MQD on 4/17/15.
   - Completed review of the sample frame file crosswalks (with provider email addresses), provided by the health plans, on 4/21/15.
   - Sent provider survey sample frames to subcontractor on 4/24/15.
   - Selected survey samples in the beginning of May.
   - Mailed first provider surveys and cover letters to all sampled providers and launched website for providers to complete the survey via Internet on 5/18/15.
   - Sent first electronic reminders via email notification to non-respondents with available email addresses on 6/3/15.

- Mailed third provider surveys and cover letters to all non-respondents mid-June.
- Submitted weekly disposition report to the MQD on 6/22/15 and 6/26/15.

6. Annual Technical Report –

- In May began preparing templates for each health plan's reporting of initiatives taken to address recommendations made in last year's technical report.
- Then, prepared documentation of 2014 EQRO recommendations and provided them to the MQD for review and approval prior to requesting updates from the plans.
- Received the MQD's approval and sent the requests for documentation of improvement activities to the plans on 6/30/15.
- Documentation was due back to HSAG on 8/14/15 for inclusion in the 2015 annual technical report.

QUEST Integration Dashboard
The MQD receives dashboard on QUEST Integration program monthly (see Attachment A for months April, May, and June 2015). These reports allow MQD to track provider network, claims processing, processing of prior authorization, and call center statistics at a glance.

Demonstration Evaluation
MQD submitted its QUEST Integration Draft Evaluation Design to CMS on December 18, 2014.

Enclosures/Attachments
Attachment A QUEST Integration Dashboard- June 2015

MQD Contact(s)
Jon D. Fujii
Research Officer
601 Kamokila Blvd. Ste. 506A
Kapolei, HI 96707
808 692 8093 (phone)
808 692 8087 (fax)

Date Submitted to CMS
September 2, 2015

	Apr-15					May-15					Jun-15				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United
# Members															
Medicaid	61,802	150,611	27,709	26,807	22,862	61,799	150,698	28,052	27,089	23,256	62,258	151,416	28,271	27,599	23,707
Duals	632	917	356	14,217	15,788	708	1,001	367	14,079	15,705	742	1,068	378	13,930	15,724
Total	**62,434**	**151,528**	**28,065**	**41,024**	**38,650**	**62,507**	**151,699**	**28,419**	**41,168**	**38,961**	**63,000**	**152,484**	**28,649**	**41,529**	**39,431**
# Network Providers															
PCPs	454	645	0	686	909	456	641	0	692	906	448	643	0	693	904
PCPs - (accepting new members)	289	489	0	418	795	293	486	0	419	791	286	487	0	419	788
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	132	135	207	96	38	133	137	214	96	39	135	139	216	96	40
PCPs - # in Clinics (accepting new members)	124	29	194	96	38	125	33	205	96	39	127	33	208	96	40
Specialists	2,248	2,128	333	1,502	1,582	2,267	2,136	360	1,519	1587	2273	2,162	365	1,516	1589
Specialists (accepting new members)	1,010	2,128	333	951	1,548	1,021	2,136	360	956	1553	1030	2,162	365	955	1554
Behavioral Health	706	1,301	61	625	787	707	1,298	59	632	802	709	1,307	61	632	810
Behavioral Health (accepting new members)	529	1,301	61	577	776	531	1,298	59	577	791	533	1,307	61	576	800
Hospitals	25	26	14	24	22	25	26	14	24	24	26	26	14	24	24
LTSS Facilities (Hosp./NF)	44	33	16	38	29	45	33	16	38	34	45	33	16	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	313	490	372	991	978	322	492	296	996	985	337	493	346	983	960
HCBS Providers (except residential settings and LTSS facilities)	39	178	33	151	300	41	180	31	151	286	42	165	38	143	224
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,555	1,743	125	1,738	959	1563	1,754	111	1,704	987	1570	1,755	109	1,723	974
Total # of providers	**5,516**	**6,679**	**1,161**	**5,851**	**5,604**	**5,559**	**6,697**	**1,101**	**5,852**	**5,650**	**5,585**	**6,723**	**1,165**	**5,848**	**5,559**
Call Center															
# Member Calls	3,917	7,933	520	11,717	5,109	3,413	7,213	504	10,037	4,083	3,258	7,685	640	10,027	4,270
Avg. time until phone answered	0:00:12	0:00:05	0:00:19	0:00:22	0:00:24	0:00:22	0:00:08	0:00:12	0:00:26	0:00:19	0:00:14	0:00:07	0:00:13	0:00:26	0:00:18
Avg. time on phone with member	4:27	4:57	3:37	0:08	5:21	4:32	5:02	3:05	0:08	5:16	4:46	5:12	3:00	0:08	0:05:16
% of member calls abandoned	2%	0%	3%	2%	1.8%	5%	1%	2%	2%	1.9%	3%	1%	1%	3%	1.4%
# Provider Calls	7,510	8,444	296	4,198	3,451	7,702	7,858	165	4,000	3,153	7,773	8,534	328	4,490	3,427
Avg. time until phone answered	0:00:13	0:00:26	0:00:14	0:00:39	0:00:03	0:00:23	0:00:38	0:00:17	0:00:44	0:00:04	0:00:14	0:00:32	0:00:11	0:00:33	0:00:05
Avg. time on phone with provider	4:30	4:37	2:24	0:09	6:24	4:27	5:13	2:17	0:09	6:22	4:32	4:18	2:23	0:08	0:06:19
% of provider calls abandoned	2%	2%	4%	3%	0.4%	5%	3%	3%	3%	0.4%	2%	3%	5%	5%	0.6%
Medical Claims- Electronic															
# Submitted, not able to get into system	422	1,549		4,171	1,074	286	1,515		3,707	968	144	1,475		3,661	897
# Received	32,758	125,557	604	64,198	40,914	36,991	119,621	724	70,633	48,413	38,183	120,406	734	66,775	44,835
# Paid	33,544	137,596	465	41,129	43,996	32,728	105,462	573	49,053	49,381	35,467	108,162	673	44,151	48,092
# In Process	3,972	29,700	121	18,135	8,605	6,075	38,727	123	17,212	1,425	7,110	45,117	50	18,198	6,730
# Denied	2,177	6,005	18	4,934	1,094	1,863	5,130	28	4,368	1,723	1,804	5,854	13	4,426	1,635
Avg time for processing claim in days (month to date)	4	10	5	6	8	5	10	6	7	8	5	9	4	7	9
Medical Claims- Paper															
# Submitted, not able to get into system	428	1,279		611	556	256	1,018		419	392	336	1,111		406	307
# Received	18,323	19,516	632	20,382	27,411	17,844	19,150	381	16,463	19,606	20,423	20,401	533	16,865	15,339
# Paid	16,879	21,151	526	7,895	30,684	13,962	15,917	267	7,891	19,861	17,374	18,051	440	8,588	18,270
# In Process	4,198	8,335	75	10,429	6,362	5,657	10,279	100	5,266	447	7,711	10,240	70	5,533	1,794
# Denied	2,887	1,843	31	2,058	455	2,243	1,293	14	3,306	244	2,513	2,389	26	2,744	234
Avg time for processing claim in days (month-to-date)	6	16	6	9	7	7	16	7	11	7	8	15	7	9	7
Prior Authorization (PA)- Electronic															
# Received	80	479	496	144	38	117	470	550	136	19	102	470	413	117	40
# In Process	11	142	0	1	0	47	137	0	14	1	10	178	0	6	1
# Approved	69	413	486	147	33	70	425	542	125	16	92	396	398	114	37
# Denied	0	59	8	1	5	0	50	5	2	2	0	33	13	3	2
Avg time for PA in days (month to date)	5	9	6	1	3	8	9	4	1	4	8	9	5	1	2
Prior Authorization (PA)- Paper and Telephone															
# Received	1,370	735	0	1559	2,578	1,472	745	0	1346	2,426	1,412	722	0	1656	2,494
# In Process	111	0	0	508	53	238	0	0	314	51	159	0	0	281	49
# Approved	1,251	516	0	1416	2,297	1,227	560	0	1506	2,135	1,237	550	0	1574	2,201
# Denied	8	219	0	24	228	7	185	0	34	240	16	172	0	85	244
Avg time for PA in days (month-to-date)	4	0	0	4	3	4	0	0	4	3	4	0	0	5	3
# Non-Emergency Transports															
Ground	635	816	80	9,833	8,301	840	785	113	9,526	7,986	862	889	86	9,690	8,432
Air	477	686	1	725	135	570	623	2	564	183	540	681	7	901	337
* round trip															
# Member Grievances															
# Received	19	16	12	80	77	20	16	11	70	68	21	16	5	61	60
# Resolved	20	15	10	89	84	25	16	15	82	73	16	17	2	78	74
# Outstanding	12	10	4	61	49	7	10	0	49	44	12	9	3	32	30
# Provider Grievances															
# Received	6	0	1	0	2	7	1	0	2	2	5	0	0	0	2
# Resolved	2	1	0	1	1	5	0	1	0	3	8	1	0	2	1
# Outstanding	8	0	1	0	2	10	1	0	2	1	7	0	0	0	2
# Member Appeals															
# Received	1	32	1	1	14	0	30	0	5	14	1	27	3	4	8
# Resolved	2	41	0	1	12	1	35	1	2	7	1	28	1	6	15
# Outstanding	1	19	1	1	9	0	14	0	4	16	0	13	2	2	9
# Provider Appeals															
# Received	0	2	0	0	106	0	8	0	26	75	0	2	0	36	90
# Resolved	0	2	5	2	66	0	1	0	3	120	0	1	0	2	125
# Outstanding	0	3	0	3	206	0	10	0	26	161	0	11	0	60	126
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	75	80	3	137	169	83	129	3	150	148	86	138	3	135	166
Inpatient Acute Days * (A) - per 1,000	361	365	13	770	712	397	318	19	877	690	380	368	11	813	765
Readmissions within 30 days* (A)	36	233	0	133	28	37	212	0	120	27	38	223	0	117	29
ER Visits * (C) - per 1,000**	581	437	17	748	559	587	452	21	759	672	557	426	18	724	668
# Prescriptions (C) - per 1,000	8,710	9,759	691	14,025	14,553	8,317	9,563	696	13,747	13,832	7,476	9,417	642	13,963	13,691
Waitlisted Days * (A) - per 1,000	31	0	0	57	16	34	0	2	35	8	33	0	1	14	8
NF Admits * (A)	16	11	2	6	2	26	24	0	8	8	15	18	3	10	7
# Members in NF (non-Medicare paid days) (C)**	18	40	16	1,260	819	13	46	21	1,235	1,111	39	48	6	1,164	1,105
# Members in HCBS **(C)- note: member can be included in more than one category listed below	10	186	22	2,244	1,842	14	203	46	2,187	2,210	22	214	56	2,168	2,220
# Members in Residential Setting **(C)	2	70	12	716	950	4	82	9	700	1,026	8	93	15	662	1,024
# Members in Self-Direction **(C)	10	30	7	865	851	13	40	12	861	881	17	42	12	887	887
# Members receiving other HCBS **(C)	11	118	10	1,379	892	16	124	37	1,326	1,006	17	121	51	1,281	1,024

(* 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
ER= Emergency Room
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
PA= Prior Authorization
PCP= Primary Care Provider
QI= QUEST Integration
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: 6/30/2015

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)	264	54	10	1	41	43	35	448
PCPs - (accepting new members)	**168**	**28**	**7**	**1**	**32**	**25**	**25**	**286**
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	69	10	5	3	4	19	25	135
PCPs - # in Clinics (accepting new members)	**63**	**10**	**5**	**3**	**4**	**17**	**25**	**127**
Specialists	1719	204	26	2	109	101	112	2,273
Specialists (accepting new members)	**785**	**111**	**7**	**1**	**43**	**34**	**49**	**1,030**
Behavioral Health	435	89	5	3	44	67	66	709
Behavioral Health (accepting new members)	**323**	**65**	**4**	**2**	**33**	**54**	**52**	**533**
Hospitals	13	2	1	1	3	1	5	26
LTSS Facilities (Hosp./NF)	26	4	0	1	6	3	5	45
Residential Setting (CCFFH, E-ARCH, and ALF)	275	14	0	0	9	32	7	337
HCBS Providers (except residential settings and LTSS facilities)	15	5	3	3	5	6	5	42
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1030	180	16	14	110	117	103	1,570
Totals	**3,846**	**562**	**66**	**28**	**331**	**389**	**363**	**5,585**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	32,755	9,142	2,138	490	5,933	6,287	6,255	**63,000**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	98	143	143	123	132	101	104	108

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)	414	57	8	18	42	63	41	643
PCPs - (accepting new members)	**319**	**27**	**7**	**13**	**38**	**49**	**34**	**487**
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	64	8	2	3	6	18	38	139
PCPs - # in Clinics (accepting new members)	**7**	**3**	**2**	**1**	**4**	**0**	**16**	**33**
Specialists	1434	210	37	11	141	124	205	2,162
Specialists (accepting new members)	**1434**	**210**	**37**	**11**	**141**	**124**	**205**	**2,162**
Behavioral Health	805	142	7	2	85	147	119	1,307
Behavioral Health (accepting new members)	**805**	**142**	**7**	**2**	**85**	**147**	**119**	**1,307**
Hospitals	13	2	1	1	3	1	5	26
LTSS Facilities (Hosp./NF)	23	2	1	0	2	4	1	33
Residential Setting (CCFFH, E-ARCH, and ALF)	405	16	0	0	11	45	16	493
HCBS Providers (except residential settings and LTSS facilities)	68	24	8	7	19	26	13	165
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1091	193	18	23	120	139	171	1,755
Totals	**4,317**	**654**	**82**	**65**	**429**	**567**	**609**	**6,723**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	94,090	8,866	668	121	9,088	24,303	15,348	**152,484**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	197	136	67	6	189	300	194	195

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)	0	0						0
PCPs - (accepting new members)	**0**	**0**						**0**
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	160	56						216
PCPs - # in Clinics (accepting new members)	**154**	**54**						**208**
Specialists	325	40						365
Specialists (accepting new members)	**325**	**40**						**365**
Behavioral Health	51	10						61
Behavioral Health (accepting new members)	**51**	**10**						**61**
Hospitals	12	2						14
LTSS Facilities (Hosp./NF)	15	1						16
Residential Setting (CCFFH, E-ARCH, and ALF)	313	33						346
HCBS Providers (except residential settings and LTSS facilities)	29	9						38
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	79	30						109
Totals	**984**	**181**	**0**	**0**	**0**	**0**	**0**	**1,165**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	18,840	9,809						**28,649**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	118	175	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	133

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)	463	50	6	7	72	70	25	693
PCPs - (accepting new members)	**290**	**26**	**5**	**6**	**46**	**28**	**18**	**419**
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	67	2	1	1	2	10	13	96
PCPs - # in Clinics (accepting new members)	**67**	**2**	**1**	**1**	**2**	**10**	**13**	**96**
Specialists	1149	97	13	4	114	74	65	1,516
Specialists (accepting new members)	**683**	**83**	**13**	**4**	**54**	**64**	**54**	**955**
Behavioral Health	442	46	4	0	34	67	39	632
Behavioral Health (accepting new members)	**409**	**34**	**3**	**0**	**33**	**60**	**37**	**576**
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)	826	40	0	0	16	78	23	983
HCBS Providers (except residential settings and LTSS facilities)	98	9	2	0	6	21	7	143
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1088	175	16	6	133	157	148	1,723
Totals	**4,167**	**424**	**44**	**20**	**385**	**480**	**328**	**5,848**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	25,910	4,533	509	104	2,018	5,365	3,090	**41,529**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	49	87	73	13	27	67	81	53

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)	645	70	10	5	73	58	43	904
PCPs - (accepting new members)	**569**	**61**	**8**	**5**	**73**	**37**	**35**	**788**
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	20	0	0	0	4	13	3	40
PCPs - # in Clinics (accepting new members)	**20**	**0**	**0**	**0**	**4**	**13**	**3**	**40**
Specialists	1199	89	32	0	121	63	85	1,589
Specialists (accepting new members)	**1176**	**89**	**32**	**0**	**121**	**52**	**84**	**1,554**
Behavioral Health	578	88	2	1	27	64	50	810
Behavioral Health (accepting new members)	**575**	**84**	**2**	**1**	**26**	**62**	**50**	**800**
Hospitals	11	2	1	1	3	3	3	24
LTSS Facilities (Hosp./NF)	25	2	0	0	3	3	1	34
Residential Setting (CCFFH, E-ARCH, and ALF)	799	30	0	0	17	94	20	960
HCBS Providers (except residential settings and LTSS facilities)	180	16	0	0	6	18	4	224
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	674	105	6	2	70	61	56	974
Totals	**4,131**	**402**	**51**	**9**	**324**	**377**	**265**	**5,559**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	25,287	3,473	144	34	2,290	5,510	2,693	**39,431**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	38	50	14	7	30	78	59	42

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls

as of: 6/30/2015

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	60	7	0	0	4	3	4	**78**
Network (provider look up, access)	317	7	0	0	6	8	1	**339**
Primary Care Physician Assignment or Change	413	26	4	0	11	23	33	**510**
NEMT (inquiry, scheduling) -*monthly report*	101	24	15	4	11	24	16	**195**
Authorization/Notification (prior auth status)	417	46	17	9	23	38	16	**566**
Eligibility (general plan eligiblity, change request)	803	57	4	6	22	27	16	**935**
Benefits (coverage inquiry)	133	5	1	0	3	6	7	**155**
Enrollment (ID card request, update member information)	94	8	0	1	2	5	2	**112**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	35	5	0	0	3	3	1	**47**
Billing/Payment/Claims	569	45	5	1	22	16	31	**689**
Appeals	4	0	1	1	0	0	0	**6**
Complaints and Grievances	0	0	0	0	0	0	0	**0**
Other	847	22	5	7	10	21	16	**928**
Totals	**3,793**	**252**	**52**	**29**	**117**	**174**	**143**	**4,560**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	35	7	0	0	5	4	5	**56**
Network (provider look up, access)	40	8	0	0	2	14	8	**72**
Primary Care Physician Assignment or Change	1435	158	13	2	161	310	234	**2313**
NEMT (inquiry, scheduling) -*monthly report*	60	101	39	19	94	337	192	**842**
Authorization/Notification (prior auth status)	18	3	0	0	2	6	8	**37**
Eligibility (general plan eligiblity, change request)	377	39	1	0	17	49	34	**517**
Benefits (coverage inquiry)	163	26	1	0	19	37	33	**279**
Enrollment (ID card request, update member information)	603	53	6	3	39	141	89	**934**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	8	2	0	0	1	2	0	**13**
Billing/Payment/Claims	120	19	1	0	14	19	23	**196**
Appeals	1	1	0	0	1	0	0	**3**
Complaints and Grievances	14	1	0	0	1	4	5	**25**
Other	658	81	2	1	42	122	93	**999**
Totals	**3,532**	**499**	**63**	**25**	**398**	**1,045**	**724**	**6,286**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	5	0						**5**
Network (provider look up, access)	62	17						**79**
Primary Care Physician Assignment or Change	0	0						**0**
NEMT (inquiry, scheduling) -*monthly report*	3	3						**6**
Authorization/Notification (prior auth status)	13	2						**15**
Eligibility (general plan eligiblity, change request)	438	83						**521**
Benefits (coverage inquiry)	98	26						**124**
Enrollment (ID card request, update member information)	29	11						**40**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	95	12						**107**
Appeals	0	1						**1**
Complaints and Grievances	2	0						**2**
Other	59	9						**68**
Totals	**804**	**164**	**0**	**0**	**0**	**0**	**0**	**968**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	484	98	15	0	20	114	35	**766**
Network (provider look up, access)	51	13	0	0	1	15	7	**87**
Primary Care Physician Assignment or Change	229	34	6	0	11	74	29	**383**
NEMT (inquiry, scheduling) -*monthly repor*t	3014	724	69	12	120	630	626	**5195**
Authorization/Notification (prior auth status)	260	62	24	3	15	61	40	**465**
Eligibility (general plan eligiblity, change request)	428	48	9	1	16	49	22	**573**
Benefits (coverage inquiry)	244	44	1	0	7	40	27	**363**
Enrollment (ID card request, update member information)	417	83	16	0	11	124	36	**687**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	315	72	16	0	15	77	21	**516**
Billing/Payment/Claims	1225	196	27	9	89	189	113	**1848**
Appeals	14	8	0	0	0	4	3	**29**
Complaints and Grievances	22	13	2	0	0	11	2	**50**
Other	1669	317	47	7	73	360	164	**2637**
Totals	**8,372**	**1,712**	**232**	**32**	**378**	**1,748**	**1,125**	**13,599**

UNITED HEALTHCARE

	Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
A	Pharmacy - (claim, coverage, access)	35	6	0	0	4	14	4	**63**
B	Network (provider look up, access)	250	44	0	1	14	34	31	**374**
C	Primary Care Physician Assignment or Change	397	63	0	0	31	60	47	**598**
D	NEMT (inquiry, scheduling) -*monthly repor*t	33	13	1	2	11	50	15	**125**
E	Authorization/Notification (prior auth status)	95	28	3	1	19	54	15	**215**
F	Eligibility (general plan eligiblity, change request)	352	43	1	0	27	70	41	**534**
G	Benefits (coverage inquiry)	45	6	0	0	2	7	8	**68**
H	Enrollment (ID card request, update member information)	538	81	0	0	44	126	46	**835**
I	Service Coordination Inquiry or request (contact FSC, assessment, service plan)	160	21	1	0	7	37	26	**252**
J	Billing/Payment/Claims	497	84	4	0	41	172	74	**872**
K	Appeals	0	0	0	0	0	0	0	**0**
L	Complaints and Grievances	10	1	0	0	2	6	5	**24**
Z	Other	1,250	184	1	3	103	244	130	**1915**
	Totals	**3,662**	**574**	**11**	**7**	**305**	**874**	**442**	**5,875**