Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2020 3rd Quarter
(DY26 Q3)

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: August 31, 2020

Reporting Period: April 2020 – June 2020

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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. Ongoing regular meetings have been established for the "HOPE Leadership Team" to ensure HOPE initiatives were woven into the new QI Request for Proposal (RFP). Recent meetings have focused on refining the care coordination/service coordination model for the new QI RFP. The final version of the new QUEST Integration RFP was released on August 26, 2019.

During the reporting period, MQD awarded the new QUEST RFP to four health plans. Two received statewide awards and two received Oahu-only awards. Since then, MQD received two award protests however, one was retracted. The other protest was still open as of the end of this reporting period.

As a result of the current public health emergency (PHE) declared by the federal government because of COVID-19 disease, Med-QUEST will postpone implementing new contracts with health plans until further notice so we can take the time to make sure everyone can get the care they need. Med-QUEST has taken steps to ensure members can make an appointment with their current doctor or health care provider at any time during the PHE. It is important to point out that Med-QUEST was required to suspend all operations relating to the contract

implementation because a protest was filed. Our decision to postpone the implementation of the contracts is occurring regardless of the outcome of the protest.

MQD leadership continued targeted communications with QI health plans during the PHE. The task force that began meeting three times a week, reduced the meeting frequency to two times a week, with an enhanced focus on ensuring HCBS residential settings have the PPE needed to prevent the spread of COVID-19. Also, the Medicaid Director continued to meet with health plan CEOs once a week to discuss high-level issues around COVID-19. Finally, 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(c) flexibilities during the PHE. Furthermore, MQD partnered 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. Finally, in alignment with Hawaii statewide efforts to reduce the spread of COVID-19, MQD enabled its staff to work from home wherever feasible and practical.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality workbook for the quarter ending March 31, 2020 was submitted to CMS by the May 31, 2020 deadline. The Budget Neutrality spreadsheet for the quarter ending June 30, 2020 will be submitted separately by the August 31, 2020 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

The State of Hawaii Organ and Tissue Transplant contract was awarded and executed during this reporting period.

B. Benefits & Benefit Changes

Compliance with Section 1115 Demonstration Special Terms and Conditions

MQD continued monthly monitoring meetings with CMS through the quarter to ensure compliance with the 1115 Special Terms and Conditions. During the third quarter, MQD submitted the Evaluation Design to CMS April 30, 2020. CMS replied to MQD with their feedback on May 29, 2020. MQD finalized its Evaluation Design, based on CMS feedback, in the fourth quarter, on July 31, 2020. The 2019 Annual 1115 Demonstration report was submitted on May 4, 2020.

HOPE initiative

PPDO 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, further developing behavioral health integration 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.

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. MQD staff continues to attend meetings, offer guidance, assistance and information when needed. The DOE hired additional staff to assist in Administrative claiming issues and Medicaid billing, including a mainland consultant who specializes in these two areas. DOE continues outreach for consent forms, and work with providers to ensure requirements for Medicaid claiming have been met. The main focus for this quarter has been working on Administrative Claiming and a school health services SPA through collaboration with CMS.

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.

No Hawaii Administrative Rules were amended, however, during this period, two (2) SPAs were approved: 1) Request for Waiver under Section 1135-The approval is included in the SPA 20-0002 approval (Date approved on April 30, 2020) 2) Appendix K: Emergency Preparedness and Response and COVID-19 Addendum (Date approved May 18, 2020).

Policy and Program Directives

Part of PPDO's responsibilities include drafting and issuing of Policy and Program Directives (PPDs) to MQD staff for information, clarification and action on affected individuals. PPDs are drafted during the year as requests for clarification of current rules are submitted, or to inform staff of upcoming changes in policy or programs until the Hawaii Administrative rules are amended. No PPDs were issued during this quarter.

To inform providers of specific policy changes, the following provider memos were released during this period:

- **QI-2021** - 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

PPDO remains committed to 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.

C. Enrollment and Disenrollment

Med-QUEST Division maintains a steady number of Medicaid applications completed by phone, generally just under 1,000 each quarter. The phone process encourages the applicant to pre-select a QUEST Integration health plan. Clients that apply by paper or online are auto-assigned a health plan and mailed a choice form.

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

Disenrollment Summary

	# of Beneficiaries	Reason
Beneficiaries that requested plan-to-plan change with cause	7	**4 Continuity of Care** ○ 3 primary care physician not participating with plan ○ 1 continuity with former commercial plan. **3 Service coordination** ○ 2 LTC Foster Care Home operator not participating ○ 1 Newborn 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	43	
Beneficiaries that changed health plan after being auto-assigned	5,027	

D. Quality of Care

[See EQRO information in section XIV.]

E. Access that is Relevant to the Demonstration

MQD worked to expand the availability of telehealth during the PHE. In particular, MQD allowed telephony to be a reimbursable telehealth modality, aligned the Hawaii telehealth standards with Federal DHS/OCR guidance on appropriate telehealth applications, expanded FQHC ability to receive PPS payment for a telehealth visit when the FQHC provider is not at the FQHC when providing telehealth services, by granting hub location flexibility, and allowed FQHC PPS payment for telehealth services delivered to homeless individual.

MQD issued memorandum in the previous quarter 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. Memorandum containing this guidance will be issued in FFY2021-Q1.

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.

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 is expected to go to court in the 3rd quarter of FFY 2020.

MQD is also pursuing litigation against Liberty Dialysis for alleged over-billing. This case is expected to go to court in the 3rd quarter of FFY 2020.

IV. Grievances and Appeals

A. Grievance Events that Affect Health Care Delivery

See section IV.B. 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.

Grievances to MQD Health Care Services Branch (HCSB)

April 2020 – June 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	4
Provider/Provider Staff Behavior/Services	8
Transportation Customer Service	2
Treatment Plan/Diagnosis	6
Fraud and Abuse of Services	1
Billing/Payments	1
Member Rights	1
Medication	5
General Information	2
Forward to Other Departments	17
Total	**47**

Some grievances fit into multiple categories.

Month	# of Member Grievances Addressed by HCSB
April 2020	15
May 2020	16
June 2020	12
Total	**43**

Status of Member Grievances Addressed by HCSB					
		April 2020	May 2020	June 2020	**TOTAL**
Received		15	16	12	43
Status					
Referred to Subject Matter Expert		6	7	3	16
Health Plan resolved with Members		5	7	4	16
Member withdrew grievance		0	0	0	0
Resolution in Health Plan favor		1	2	4	7
Resolution in Member's favor		1	0	1	2
Still awaiting resolution		0	0	0	0
Return to Health Plan awaiting Resolution Letter		2	0	0	2
Carry-over from previous Quarter		13*	0	0	13

*This contains a carry-over from 5/14/19 working with eligibility to resolve issues related to bills received for services not used by member.

Grievances to Health Plans

In addition to information for this reporting period, the tables below also includes information for the previous reporting period, FFY 2020 2nd quarter (January-March 2020), since such information was either not complete or unavailable to report in the last quarterly monitoring report to CMS, due to the COVID-19 pandemic.

Types of Member Grievances Reported to Health Plans			
Medical		Jan-Mar 2020	Apr-Jun 2020
Provider Policy		11	10
Health Plan Policy		25	23
Provider/Provider Staff Behavior		71	79
Health Plan Staff Behavior		34	35
Appointment Availability		8	10
Network Adequacy/ Availability		3	3

Waiting Times (office, transportation)		76	53
Condition of Office/ Transportation		0	4
Transportation Customer Service		15	11
Treatment Plan/Diagnosis		16	24
Provider Competency		13	13
Interpreter		0	0
Fraud and Abuse of Services		2	4
Billing/Payments		19	22
Health Plan Information		14	0
Provider Communication		18	15
Member Rights		12	19
Total		337	325

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			
		Jan-Mar 2020	Apr-Jun 2020
Total number filed during the reporting period		321	268
Status received from Health Plans			
Total number that received timely acknowledgement from health plan		314	26
Total number not receiving timely acknowledgement from health plan		7	6
Total number expected to receive timely acknowledgement during next reporting period		0	0
Total number that received timely decision from health plan		300	246
Total number not receiving timely decision from health plan		16	16
Total number expected to receive timely decision during next reporting period		14	15
Total number currently unresolved during the reporting period		18	19

Appeals to the Health Plans

In addition to information for this reporting period, the next two tables also include information for the previous reporting period, FFY 2020 2nd quarter (January-March 2020), since such information was either not complete or unavailable to report in the last quarterly monitoring report to CMS, due to the COVID-19 pandemic.

During April 2020 – June 2020, there were a total of 308 Appeals submitted with the Health Plans.

Types of Member Appeals to Health Plans				
		Jan-Mar 2020	Apr-Jun 2020	**TOTAL**
Service denial		76	64	140
Service denial due to not a covered benefit		45	56	101
Service denial due to not medically necessary		238	177	415
Service reduction, suspension or termination		0	2	2
Payment denial		9	12	21
Timeliness of service		0	0	0
Prior authorization timeliness		0	0	0
Other		10	4	14

Status of Member Appeals to Health Plans				
		Jan-Mar 2020	Apr-Jun 2020	**TOTAL**
Total number filed during the reporting period		374	308	682
Status received from Health Plans				
Total number that received timely acknowledgement from health plan		362	304	666
Total number not receiving timely acknowledgement from health plan		11	2	13
Total number expected to receive timely acknowledgement during next reporting period		1	2	3
Total number that received timely decision from health plan		349	270	619
Total number not receiving timely decision from health plan		15	24	39
Total number expected to receive timely decision during next reporting period		24	32	56
Total number currently unresolved during the reporting period		24	32	56
Total number overturned		238	174	412

Appeals to the State (State Fair Hearings)

There were a total of 7 Appeals submitted to AAO. All were resolved in member's favor and did not require a hearing.

<u>Types</u> of Member Appeals to State Administrative Appeals Office (AAO)					
		April 2020	May 2020	June 2020	**TOTAL**
Medical		4	1	0	5
Home and Community Based Services (HCBS)		0	0	1	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		0	0	0	0
Miscellaneous		1	0	0	1

<u>Status</u> of Member Appeals to State Administrative Appeals Office (AAO)					
		April 2020	May 2020	June 2020	**TOTAL**
Submitted		5	1	1	7
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		5	1	1	7
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		0	0	0	0

V. Adverse Incidents

A. Long Term Services and Supports (LTSS)

In addition to information for this reporting period, the table below also includes information for the previous reporting period, FFY 2020 2nd quarter (January-March 2020), since such information was either not complete or unavailable to report in the last quarterly monitoring report to CMS, due to the COVID-19 pandemic.

For January to March, there were 363 adverse events, and for April to June, there were 339. Combined there were a total of 702 adverse events. The "Fall" category remains the top occurring incident.

Types of Adverse Events MQD				
		Jan-Mar 2020	Apr-Jun 2020	**TOTAL**
Fall		142	120	262
Hospital		90	96	186
Death		35	27	62
Emergency Room Visit		62	51	113
Injury		34	45	79
TOTAL		363	339	702

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

B. Medicaid Certified Nursing Facilities

Total of 16 reported adverse incident reports submitted during the period of April 2020 – June 2020.

- 9 unattended/unwitnessed falls
- 3 witnessed falls
- 1 rib fracture
- 1 back pain
- 1 left foot laceration
- 1 arm bruise

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

C. Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities

Total of 5 reported adverse incident reports submitted during the period of April 2020 – June 2020.

- 1 unattended death.
- 1 ER visit due to pneumonia. Negative COVID test.
- 1 ER visit due to bacterial pneumonia and seizure. Negative COVID test.
- 1 ER visit due to epileptic seizure.
- 1 ER visit due to cellulitis

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 exclusively 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 3nd 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 3.

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 was completed. An action plan for transition of cases is being drafted in preparation upon termination of the health pandemic emergency (HPE) period.

B. Administration

In May 2020, Hawaii procured an Asset Verification System (AVS) vendor leveraging the efforts of the New England States Consortium System Organizations (NESCSO) and its multi-state contract for electronic asset verification services with Public Consulting Group (PCG). Also, in May Hawaii submitted a corrective action plan informing CMS of its approach and schedule to come into compliance with the requirements in Section 1940 of the Social Security Act (the Act) to implement an Asset Verification System (AVS). Hawaii implemented an AVS portal in July 2020 and is actively engaged in the design, development, and implementation to integrate AVS directly to its eligibility system.

C. Budget

See section IX. below.

VIII. Expenditure Containment Initiatives

No new containment initiatives for this reporting period.

IX. Financial/Budget Neutrality Development/Issues

For this reporting period, there were several prior period adjustments in capitation due to retroactive rate changes for the second half of calendar year 2018, all of calendar year 2019, and a portion of the first half of calendar year 2020. These are 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**	**Apr 2020 – Jun 2020**	**Apr 2020 – Jun 2020**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	358,074	115,682
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	110,180	34,796
Aged	Aged w/Medicare Aged w/o Medicare	86,937	29,061
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	71,304	24,009
Expansion State Adults	Expansion State Adults	311,046	99,606
Newly Eligible Adults	Newly Eligible Adults	63,208	19,807
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,704	496
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)	87,368	28,724
Total		**1,089,821**	**352,245**

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	204,108
Title XXI funded State Plan	28,724
Title XIX funded Expansion	119,413
Enrollment current as of	6/30/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 6/30/20
EG 1 – Children	**116,194**	**123,449**	**120,135**	**359,778**
EG 2 – Adults	**34,104**	**38,769**	**37,307**	**110,180**
EG 3 – Aged	**28,362**	**29,083**	**29,492**	**86,937**
EG 4 – Blind/Disabled	**22,416**	**24,421**	**24,467**	**71,304**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**113,064**	**132,066**	**129,124**	**374,254**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 6/30/20
State Plan Children	**115,635**	**122,872**	**119,567**	**358,074**
State Plan Adults	**34,104**	**38,769**	**37,307**	**110,180**
Aged	**28,362**	**29,083**	**29,492**	**86,937**

Blind or Disabled	22,416	24,421	24,467	71,304
Expansion State Adults	93,475	110,098	107,473	311,046
Newly Eligible Adults	19,589	21,968	21,651	63,208
Optional State Plan Children	0	0	0	0
Foster Care Children, 19-20 years old	559	577	568	1,704
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

Behavioral Health Programs Administered by the Department of Health (DOH)

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.	**4,541**
Early Intervention Program (EIP/DOH)	**889**

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).	
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.	**955**

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.

LTSS Enrollment [Data received as of August 25, 2020]

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**

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) adjusted to teleworking immediately when the National Health Emergency due to COVID-19 was declared as our branch is equipped with the technology to work and assist the community with enrollment assistance remotely.

HCOB along with our community partners brainstormed, strategized and developed out-of-the-box ways to continue to conduct outreach, provide education and enrollment assistance in a remote way. Businesses were shut down and many Hawaii residents were laid off and lost their health coverage. Created flyers with pertinent information and contacts, distributed them by email and/or hard copy to other organizations and entities who were servicing displaced employees and struggling individuals and families, such as Food Drives/Banks/Pantry's, Grab-N-Go Meals with Department of Education; Unions statewide, HR departments with the various Hotel chains statewide, Urgent Care Centers. Proactively contacted other small business, places of worship, to provide information on how to apply for health coverage. Continuing to process applications and change of circumstances for those who are incarcerated and in public institutions to help ensure a smooth transition and access to health coverage upon being released.

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

Member Choice of Health Plan Exercised

April 2020 – June 2020	Number of Members
Individuals who chose a health plan when they became eligible	**2,127**
Individuals who were auto-assigned when they became eligible	**10,717**
Individuals who changed their health plan after being auto-assigned	**5,027**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**43**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**9**

During this reporting period, 2,127 individuals chose their health plan since they became eligible in the previous quarter, 5,027 changed their health plan after being auto-assigned.

In addition, 9 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 3rd Quarter, MQD's Health Analytics Office (HAO) submitted a received a favorable response from CMS on a draft evaluation design for the 2019-2024 1115 waiver. The UH team worked on addressing CMS comments in preparation for submission of a final evaluation design to CMS in July 2020.

XIV. Quality Assurance and Monitoring Activity

Quality Activities During the Quarter April 2020 - June 2020

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)

April:

- Provided PIP technical assistance to Ohana CCS on 04/13/20 and 04/17/20.
- Provided Module 4 plan feedback to UHC on 04/03/20.
- Received Module 4 plan submissions from Kaiser (04/14/20 and 04/20/20), Ohana (04/21/20) and Ohana CCS (04/21/20)

May:

- Provided PIP technical assistance to Kaiser on 05/12/20.
- Provided Module 4 plan feedback to Kaiser (05/07/20 and 05/08/20) and Ohana (05/14/20).
- Received Module 4 plan submissions from HMSA on 05/08/20.
- Sent Module 4 intervention progress check-ins to AlohaCare and Ohana on 05/29/20.

June:

- Provided HMSA Module 4 intervention plan pre-validation review feedback on 06/02/20.
- Requested Module 4 intervention progress update from UHC on 06/03/20.
- Provided Kaiser Module 4 intervention plan pre-validation review feedback on 06/03/20.
- Received Module 4 intervention progress updates from AlohaCare and Ohana on 06/19/20.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

April:

- Conducted virtual performance measure review/HEDIS audit with the health plans by 04/15/20.
- Received preliminary rates from the health plans by 04/17/20.

May:

- Preliminary rate review was completed by 05/01/20. The auditor followed up with the health plans regarding any outstanding items.
- MRRV Attachment 1 Final MR Summary Counts were due to HSAG by 05/18/20.
- MRRV was conducted from 05/08/20-05/29/20. The QI health plans received their results reports on the following dates:

  Aloha Care 05/20/20

  HMSA 05/28/20

  Kaiser 05/21/20

  Ohana 05/21/20

  UHC 05/19/20

June:

- The health plans submitted final rates on 06/01/20.
- HSAG completed final rate review by 06/15/20.

3. Compliance Monitoring

April:

- Continued reviewing health plan credentialing files and desk review documents.

May:

- Confirmed remote compliance review sessions with health plans:

  AlohaCare – July 29, 2020

  HMSA – July 22, 2020

KFHP – July 23, 2020

Ohana – July 27-28, 2020

UHC – July 21, 2020

- Revised compliance review agendas and disseminated them to the health plans and MQD.

June:

- Continued reviewing health plan desk review documents.

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

April:

- Mailed second postcard reminders to non-respondents on 04/03/20.
- Mailed third questionnaires and cover letters to non-respondents on 04/17/20.
- Sent weekly disposition reports to the MQD.

May:

- Sent weekly disposition reports to the MQD.
- Notified the MQD that the survey field has been extended on 05/18/20.
- Notified the MQD that the survey field has officially closed on 05/20/20.
- Received data files from subcontractor on 05/26/20.
- Submitted adult Medicaid survey data to NCQA for all QI health plans and notified the MQD that NCQA data submission was completed on 05/29/20.
- Sent the final, reconciled disposition report to the MQD on 05/29/20.

June:

- Received a copy of the signed Data Use Agreement (DUA) from the MQD on 06/22/20.
- Submitted data to the CAHPS Database on 06/24/20.

5. Provider Survey

April:

- Submitted the final sampling plan to the MQD on 04/10/20.
- Prepared and submitted the 2020 administrative forms and associated documents (e.g., cover letters and reminder text) and sample frame file instructions to the MQD for review and approval on 04/10/20.

May:

- Received completed administrative forms, including approval of letterhead for cover letters from the MQD on 05/04/20.
- Received notification that the MQD would like to postpone the survey administration until September on 05/05/20.

- Received approval of signature for cover letters from the MQD on 05/07/20.
- Received notification that the MQD would like HSAG to reach out to the provider organizations (FQHCs, Pediatrics Providers, etc.) to engage the providers to assist with improving response rates on 05/07/20.

June:

- Prepared and submitted a draft letter to encourage providers' participation in the survey for the MQD's review on 06/01/20.
- Sent an updated timeline to the MQD on 06/01/20.
- Submitted updated sample frame file instructions to the MQD on 06/23/20.
- Notified the MQD that the survey notification document was sent to the health plans to submit to their QUEST providers in the 2015 survey administration on 06/23/20.
- Received confirmation that the survey notification process performed in 2015 differs from the MQD's expectations on 06/25/20.

6. Annual Technical Report

April:

- Submitted 2020 EQR technical report template to the MQD on 04/27/20 for review and feedback by 05/08/20.

May:

- Submitted Follow-up to Prior EQRO Recommendations documentation request to health plans to address how previous EQR recommendations have been/will be addressed on 05/06/20.

June:

- Received feedback on the technical report template from the MQD on 06/01/20.

7. Technical Assistance

April:

- None at this time.

May:

- Participated in a technical assistance call regarding 2019 & 2020 P4P with the Health Analytics Office.

June:

- Provided technical assistance to the Health Analytics Office as needed.

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. This draft is currently under internal review by HAO, HCSB and the Clinical Standards Office (CSO) MQD expects to gather and complete internal staff feedback, and complete the public comment period, in FFY2021-Q1.

XVI. Other

Status of Current QUEST Integration Contract

MQD received final approval from CMS on QI RFP SC#12 in this reporting period and implemented with the MCOs.

Also, MQD sent the executed contracts from all the MCOs to CMS for final approval on QI SC#13 which includes the QI Capitation rate from January 2020 to December 2020.

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 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).

MQD continues to face the challenge we faced in the beginning of the PHE, where our provider enrollment applications were paper based only and majority of our staff began tele-working. Our clerical staff have been working hard to continue scanning our paper applications to a SharePoint site so that MQD and Koan staff could access them from home. MQD and Koan have been prioritizing 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 continuing 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 meet 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.

As MQD approaches the next quarter, we have been continuing our efforts to process new paper applications, continue to work on HOKU conversion error clean-ups and prepare for HOKU's new launch date. The new go-live date is August 3rd, and MQD will work on provider communications and updating the website. In preparation of the new launch date, MQD will host HOKU refresher courses for provider training session trainers (MCO staff) and MQD/Koan internal staff.

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 3 (Q3), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation.

During this quarter, the EVV Project Team completed the review and approval of the User Acceptance Test cases; 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. The project schedule was baselined that includes the Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The baselined dates were communicated to all Hawaii EVV stakeholders. 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 Testing scheduled for August.

MQD's future EVV workplans include:

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.

<u>APRIL</u>

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.

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.

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.

Clinical Care Guidelines

Due to the pandemic the Division had to look at how services were being provided prior to the pandemic and how we could increase availability of services to the recipients. The Division worked with the health plans and issued clinical guidance primarily focused on telehealth services. We followed Medicare guidelines in allowing coverage of services that previously were not covered (telephonic only visits, allowing limited codes to be provided by speech, occupational and physical therapists, limited visits, etc.) Additionally, guidance and, working with the managed care plans, we were able to issue guidance to the health plans on preventive measures for community-based caregivers and their residents.

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**	April 1, 2020
Attendees	Approximately 225		
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:	Project ECHO Series: COVID Preparation Series and LTSS		
For:	HCBS Providers and Open to Public		
Speaker	Curtis Toma, MQD Medical Director and Aida Wen, Project ECHO	**Location**	Zoom
Length	1 hour per session	**Date**	April 22, 2020 to Present Every Monday and Wednesday
Attendees	Approximately 100+ per session		
Description	Project ECHO® (Extension for Community Healthcare Outcomes) is a successful, innovative medical education and mentoring program that builds PCP skills and improves access to and capacity for specialty care. It uses existing technologies to nurture sustainable learning collaboratives, connecting an interdisciplinary team of experts with primary care providers in rural and underserved communities. Sessions focus on COVID prevention, screening, and interventions in long-term services and supports settings. Recorded sessions are located at https://geriatrics.jabsom.hawaii.edu/ltss/		

A. Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for April 2020 – June 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 B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 3/31/2020 is attached. The Budget Neutrality worksheet for the quarter ending 6/30/2020 will be submitted by the 8/31/2020 deadline.

B. MQD Contact(s)

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QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	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	35,487	62,653	158,153	31399	27542	37,765	63,173	161,310	32969	27931	37,851
Duals	3,671	5,828	1341	9503	15,242	3,776	5,932	1364	9518	15,494	3,849	6,084	1449	9522	15,584
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	135,327	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	50,413	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	15,469	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	8,194	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	2284	622	164	1,943
# In Process	15	285	13	108	125	27	333	3	116	171	36	336	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	1,612	111
# In Process	165	35	0	1,099	17	231	37	0	1,203	10	291	25	0	1,480	26
# Approved	1,053	361	0	1,151	34	1,061	357	0	1,229	68	1,165	539	0	1,546	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	217	0	0	1	0
# Resolved	3	2	0	0	0	62	1	0	5	0	84	1	0	1	0
# Outstanding	890	2	0	1	0	987	2	0	4	0	1,120	1	0	0	0

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Apr-20					May-20					Jun-20				
	AlohaCare	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**
# 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	26	1	3	6
# Provider Appeals															
# Received	41	5	0	37	135	24	11	0	28	105	42	13	0	59	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	241	14	0	32	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	71	3	103	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	472	413	361	294	20	516	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	12,347
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	709	750	254	260	80	680	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	1980	1,441	255	468	232	1901	1,433
# Members in Residential Setting **(C)	140	116	139	553	899	136	117	148	541	898	158	120	153	518	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	1271	1,242	101	344	194	1221	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
(* 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: 7/31/2020

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	476	84	22	12	68	81	91	834
PCPs - (accepting new members)	**399**	**73**	**19**	**10**	**56**	**68**	**80**	**705**
Specialists*	1996	279	25	0	176	73	190	2739
Specialists (accepting new members)	**1410**	**178**	**12**	**0**	**120**	**52**	**148**	**1920**
Behavioral Health*	537	114	10	3	47	79	66	856
Behavioral Health (accepting new members)	**466**	**105**	**10**	**3**	**44**	**75**	**59**	**762**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	28	3	0	1	6	6	4	48
Residential Setting (CCFFH, E-ARCH, and ALF)	492	28	1	0	9	51	15	596
HCBS Providers (except residential settings and LTSS facilities)	32	11	4	3	6	10	5	71
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1252	240	27	14	144	127	142	1946
Totals	**4825**	**761**	**90**	**34**	**459**	**428**	**518**	**7115**

* 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	38480	8579	2263	461	5549	6462	6192	**67986**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	81	102	103	38	82	80	68	82

Note: RFP requirement is 300 members for every PCP

HMSA

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	661	90	15	14	62	104	104	1,050
PCPs - (accepting new members)	515	68	13	9	49	89	98	**841**
Specialists*	1,829	310	71	41	177	309	355	3,092
Specialists (accepting new members)	**1,829**	**310**	**71**	**41**	**177**	**309**	**355**	**3,092**
Behavioral Health*	1,046	202	8	7	90	194	135	1,682
Behavioral Health (accepting new members)	**1,046**	**202**	**8**	**7**	**90**	**194**	**135**	**1,682**
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)	482	28	1	0	12	68	22	613
HCBS Providers (except residential settings and LTSS facilities)	75	20	8	6	14	23	10	156
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,589	268	31	21	173	165	223	2,470
Totals	**5,721**	**922**	**136**	**90**	**534**	**869**	**855**	**9,127**

* 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	99300	12370	901	166	11610	27586	18666	**170,599**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	150	137	60	12	187	265	179	162

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)*	175	64						239
PCPs - (accepting new members)	**168**	**55**						**223**
Specialists*	376	93						469
Specialists (accepting new members)	**376**	**93**						**469**
Behavioral Health*	111	23						134
Behavioral Health (accepting new members)	**111**	**23**						**134**
Hospitals	10	2						12
LTSS Facilities (Hosp./NF)	17	0						17
Residential Setting (CCFFH, E-ARCH, and ALF)	147	11						158
HCBS Providers (except residential settings and LTSS facilities)	54	19						73
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	96	32						128
Totals	**986**	**244**	**0**	**0**	**0**	**0**	**0**	**1230**

* 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	23658	12112						**35770**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	135	189	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	150

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)*	543	49	9	10	73	72	42	798
PCPs - (accepting new members)	**404**	**33**	**9**	**10**	**59**	**37**	**34**	**586**
Specialists*	1166	107	13	4	113	75	69	1547
Specialists (accepting new members)	**707**	**88**	**13**	**4**	**53**	**66**	**61**	**992**
Behavioral Health*	465	49	4	0	34	72	44	668
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)	882	41	0	0	18	85	25	1051
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	**4261**	**439**	**45**	**22**	**381**	**499**	**350**	**5997**

* 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	23706	3799	406	97	1965	4632	2888	**37493**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	44	78	45	10	27	64	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)*	533	74	11	5	58	75	56	812
PCPs - (accepting new members)	**400**	**28**	**8**	**3**	**52**	**50**	**38**	**579**
Specialists*	1,221	163	63	8	112	184	159	1,910
Specialists (accepting new members)	**1,097**	**149**	**48**	**8**	**103**	**168**	**150**	**1,723**
Behavioral Health*	753	241	63	65	162	237	196	1,717
Behavioral Health (accepting new members)	**726**	**238**	**63**	**65**	**159**	**234**	**192**	**1,677**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	23	2	0	0	3	3	1	32
Residential Setting (CCFFH, E-ARCH, and ALF)	989	55	2	0	24	111	24	1,205
HCBS Providers (except residential settings and LTSS facilities)	45	11	1	0	8	18	5	88
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,288	246	16	11	141	184	155	2,041
Totals	**4862**	**795**	**157**	**90**	**511**	**816**	**599**	**7,830**

* 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	35,566	4,590	271	93	2,886	6,787	3,676	**53,869**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	67	62	25	19	50	90	66	66

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls

as of: 7/31/2020

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	10	7	1	0	1	3	4	**26**
Network (provider look up, access)	18	13	1	1	3	5	1	**42**
Primary Care Physician Assignment or Change	125	15	0	1	5	12	10	**168**
NEMT (inquiry, scheduling) -*monthly report*	94	10	2	0	3	16	6	**131**
Authorization/Notification (prior auth status)	187	30	3	1	9	34	10	**274**
Eligibility (general plan eligiblity, change request)	156	16	3	1	9	13	9	**207**
Benefits (coverage inquiry)	108	29	1	1	10	20	5	**174**
Enrollment (ID card request, update member information)	4	0	0	0	1	1	0	**6**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	112	11	0	0	8	11	3	**145**
Billing/Payment/Claims	181	18	4	1	5	5	3	**217**
Appeals	1	0	0	0	0	0	0	**1**
Complaints and Grievances	4	1	0	0	0	0	1	**6**
Other	145	30	4	1	9	15	5	**209**
Totals	**1,145**	**180**	**19**	**7**	**63**	**135**	**57**	**1,606**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	7	0	0	0	0	3	0	10
Network (provider look up, access)	74	6	0	0	9	17	16	122
Primary Care Physician Assignment or Change	1567	176	14	3	196	276	341	2573
NEMT (inquiry, scheduling) -*monthly report*	247	107	30	15	62	248	197	906
Authorization/Notification (prior auth status)	22	6	1	0	2	4	8	43
Eligibility (general plan eligiblity, change request)	381	54	3	2	40	62	63	605
Benefits (coverage inquiry)	213	37	2	0	18	39	44	353
Enrollment (ID card request, update member information)	553	80	2	0	74	148	123	980
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	26	6	1	0	5	12	5	55
Billing/Payment/Claims	173	37	3	3	34	45	30	325
Appeals	1	1	0	0	0	0	0	2
Complaints and Grievances	5	2	0	0	2	1	1	11
Other	441	77	5	1	40	81	85	730
Totals	**3710**	**589**	**61**	**24**	**482**	**936**	**913**	**6715**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	0	0						**0**
Network (provider look up, access)	27	10						**37**
Primary Care Physician Assignment or Change	2	2						**4**
NEMT (inquiry, scheduling) -*monthly report*	18	0						**18**
Authorization/Notification (prior auth status)	0	1						**1**
Eligibility (general plan eligiblity, change request)	202	44						**246**
Benefits (coverage inquiry)	96	22						**118**
Enrollment (ID card request, update member information)	31	14						**45**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	16	2						**18**
Appeals	0	0						**0**
Complaints and Grievances	0	0						**0**
Other	124	19						**143**
Totals	**516**	**114**	**0**	**0**	**0**	**0**	**0**	**630**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	269	35	3	0	14	79	22	**422**
Network (provider look up, access)	17	7	0	1	1	5	3	**34**
Primary Care Physician Assignment or Change	76	19	0	0	4	18	10	**127**
NEMT (inquiry, scheduling) -*monthly report*	1586	301	42	16	5	60	12	**2022**
Authorization/Notification (prior auth status)	22	15	17	3	1	9	10	**77**
Eligibility (general plan eligiblity, change request)	29	8	0	0	6	2	5	**50**
Benefits (coverage inquiry)	112	30	1	1	8	23	19	**194**
Enrollment (ID card request, update member information)	198	33	7	0	11	31	16	**296**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	91	16	4	0	2	23	10	**146**
Billing/Payment/Claims	25	7	0	0	4	6	2	**44**
Appeals	15	1	1	0	1	4	0	**22**
Complaints and Grievances	8	3	1	0	0	1	0	**13**
Other	667	130	19	0	47	148	69	**1080**
Totals	**3,115**	**605**	**95**	**21**	**104**	**409**	**178**	**4,527**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	120	14	2	0	19	19	15	**189**
Network (provider look up, access)	158	33	0	0	11	40	15	**257**
Primary Care Physician Assignment or Change	495	128	3	1	41	202	64	**934**
NEMT (inquiry, scheduling) -*monthly report*	29	12	0	1	8	16	11	**77**
Authorization/Notification (prior auth status)	43	4	4	2	18	26	6	**103**
Eligibility (general plan eligiblity, change request)	449	84	2	0	47	87	47	**716**
Benefits (coverage inquiry)	627	69	3	1	42	103	64	**909**
Enrollment (ID card request, update member information)	134	25	2	0	23	26	15	**225**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	107	21	1	0	5	23	13	**170**
Billing/Payment/Claims	19	2	0	0	1	4	1	**27**
Appeals	11	2	0	0	0	0	0	**13**
Complaints and Grievances	2	1	0	0	1	2	0	**6**
Other	424	71	2	0	20	86	35	**638**
Totals	**2,618**	**466**	**19**	**5**	**236**	**634**	**286**	**4,264**

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

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

ATTACHMENT B

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		$ 358,567,125	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,498,107,880
EG 2 - Adults	2		$ 158,535,036	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,165,280,833
EG 3 - Aged	3		$ 384,325,884	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,176,865,281
EG 4 – Blind/Disabled	4		$ 476,447,582	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,168,493,182
TOTAL			**$ 1,377,875,628**	**$ 1,647,483,577**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,459,963,813**

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	$ 358,567,125	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 334,837,344	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 251,128,008	$ 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	$ 158,535,036	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 305,909,469	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 229,432,102	$ 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	$ 384,325,884	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 254,723,420	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 191,042,565	$ 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	$ 476,447,582	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 360,280,676	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 270,210,507	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 941,813,182**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,537,344,718**

BASE VARIANCE			**$ 313,937,727**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,512,448,239**
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								**$ 1,512,448,239**

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)			$ 1,691,813,355	$ 3,617,720,757	$ 5,636,636,911	$ 7,753,230,770	$ 9,972,412,052	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,836,267	$ 54,265,811	$ 56,366,369	$ 38,766,154	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (313,937,727)	$ (592,361,552)	$ (884,446,566)	$ (1,190,895,813)	$ (1,512,448,239)	
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		$605,721,861	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 605,721,861**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,295,941,788**
HYPOTHETICALS VARIANCE 1			**$ 765,935,499**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,658,492,445**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ 1,066,284	$ 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	$1,429.15	
		Mem-Mon	900	3,782	3,877	3,974	4,073	
TOTAL			**$ 1,066,284**	**$ 4,695,845**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 22,047,229**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ 1,037,520	$ 4,569,466	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ 1,037,520**	**$ 4,569,466**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 21,452,210**
HYPOTHETICALS VARIANCE 2			**$ 28,764**	**$ 126,379**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 595,019**

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**	$ 2,908,053	$ 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	$3,897.67	
		Mem-Mon	900	3,782	3,877	3,974	4,073	
TOTAL			**$ 2,908,053**	**$ 12,806,873**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 60,128,775**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ 2,829,600	$ 12,462,181	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ 2,829,600**	**$ 12,462,181**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 58,506,027**
HYPOTHETICALS VARIANCE 3			**$ 78,453**	**$ 344,692**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,622,748**