Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2020 2nd Quarter

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: May 28, 2020
(via secured email)

Reporting Period: January 2020 – March 2020

Federal Fiscal Quarter:	2nd Quarter 2020
State Fiscal Quarter:	3rd Quarter 2020
Calendar Year:	1st Quarter 2020
Demonstration Year:	26th Year (8/1/19 – 7/31/20)

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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 Since then, MQD received two award protests however, one was retracted.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 has increased our communications with QI health plans during the PHE. The first step taken was to create a task force that convenes 3 times a week to discuss emergency responses to COVID-19. Also, the Medicaid Director began meeting with health plan CEOs once a week to discuss high-level issues around COVID-19. Additionally, MQD began weekly meetings with health plan CFOs to discuss financing impacts to health plans and to providers as a result of COVID-19.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality workbook for the quarter ending December 31, 2019 was submitted to CMS by the February 29, 2020 deadline. The Budget Neutrality spreadsheet for the quarter ending March 31, 2020 will be submitted separately by the May 31, 2020 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

No new contract was 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.

On January 13, 2020, MQD received an extension on our due date for the 1115 Evaluation Design that gave us a new deadline of April 1, 2020.

On January 30, 2020, MQD held its post-award forum in accordance with STC 55. The date, time, and location of the forum was published in a prominent location on the MQD website on December 30, 2019, along with the 2018 annual report.

Approximately 60 individuals joined the post-award forum either in person, over the phone, or via the webinar option that we presented. While a relatively large amount of people attended the post-award forum, the comments were not focused on the 1115 Demonstration renewal directly. MQD had recently announced a procurement award for the QI managed care program and attendees asked questions and, in some instances, expressed dissatisfaction with the result of the procurement award. The QI procurement award is currently under a bid protest and Hawaii law prohibits the State from discussing the status of the procurement while it is under protest.

On March 20, 2020, MQD submitted a request for additional 1115 flexibilities to respond to the public health emergency. CMS authorized some flexibilities surrounding our home- and community-based services benefit in the third quarter of the FFY on April 8, 2020. MQD continues to work with CMS on the approval of all the requests made on March 20, 2020.

On March 31, 2020, MQD received extensions on the due dates for our 2019 Annual 1115 Demonstration report and our 1115 Evaluation Design due to the events of the public health emergency. The Evaluation Design was submitted to CMS in the third quarter of the FFY on April 30, 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. A primary focus has been on planning for implementation of advanced Health Homes, which will be known as "Hale Ola", which was included in the MCO RFP. The focus this quarter has been to discuss different strategies in order to change the current service model in a way that works best with available resources. A smaller focused group has been meeting regularly for this phase of the HOPE initiative.

Collaboration with the Department of Education (DOE) to increase Medicaid Claiming for School Based Services

Med-QUEST continues collaboration with DOE for Medicaid billing issues. MQD staff continues to attend meetings, offer guidance, assistance and information when needed. DOE staff increased efforts statewide to be in compliance with Medicaid requirements to ensure maximum federal reimbursement for school-based Medicaid services. The DOE has hired additional staff to assist in Administrative claiming issues and Medicaid billing, including plans to hire a mainland consultant who specializes in these two areas. This quarter, the efforts of this initiative has resulted in over $300,000 in Medicaid reimbursement that previously had been paid by State funds only, total to date is over $500,000. This amount will continue to increase as additional services are billed for and when administrative claiming is implemented next year.

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, three (3) SPAs were approved: 1) SPA 20-0001 Optional State Supplementary Payment approved 02/11/20; 2) 19-0006 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act, approved 03/04/20; and 3) 19-0007 FQHC Payment Methodology for Telehealth and Teledentistry, approved 03/07/20.

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.

Four PPDs were issued this quarter : PPD 20-001, Treatment of Revocable Transfer on Death Deed(TOOD); 2) PPD 20-002, Treatment of Census Worker Income; 3) PPD-003, Increase in the Resource Limits for the Medicare Savings Programs; and 4) PPD-004, Medical Mass Change Due to the Increase in FPL for 2020.

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

- **QI-2016** - COVID-19 Pandemic Action Plan for QI Health Plans and Providers - Part IV
- **QI-2015** - COVID-19 Pandemic Action Plan for QI Health Plans - Part III

- **QI-2014** - COVID-19 Pandemic Action Plan for QI Health Plans - Part II
- **QI-2013** - Telehealth Guidance for Public Health Emergency - Telephonic Services and Services Billable by Qualified Non-Physician Health Care Professionals
- **QI-2012A** - Subacute Definitions (Addendum)
- **QI-2012** - Subacute Definitions
- **QI-2011A** - Clarification of Items and Services Carved Out from the Long-Term Care PPS Rates (Addendum)
- **QI-2011** - Clarification of Items and Services Carved Out from the Long-Term Care PPS Rates
- **QI-2010** - Telehealth Guidance During Public Health Emergency Related to COVID-19
- **QI-2009** - COVID-19 Pandemic Action Plan for QI Health Plans
- **QI-2008** - Federally Qualified Health Center Telehealth Guidance During Public Health Emergency Period in Response to COVID-19
- **QI-2007** - Tele-Health Payment Guidance for Federally Qualified Health Centers (FQHC)
- **QI-2006A** - New Provider Enrollment System - HOKU System Update (Addendum)
- **QI-2006** - New Provider Enrollment System - HOKU System Update
- **QI-2005** - New State Medicaid ID Card Design
- **QI-2004** - Revised QUEST Integration Coverage for Our Care, Our Choice Act (End of Life Care Option)
- **QI-2003** - Community Integration Services (CIS) Data Requirements
- **QI-2002** - Payment Suspension to Provider (Philip Suh, MD) - Effective January 17, 2020

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 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.

[See detailed plan enrollment information in section VIII.]

Disenrollment Summary
Information source unavailable at this time.

Outreach/Innovative Activities

The Health Care Outreach Branch (HCOB) planned for a new year of outreach. The staff participated in meetings to discuss outreach strategies and evaluate if they should be continued or changed up.

At the start of the new year we continued to provide our usual services and outreach to the community, working with homeless shelters, justice involved and those populations coming out of public institutions such as the state hospital, along with our lawfully present residents. In the month of March, the spread of Coronavirus COVID-19 reached Hawaii, our State government announced its closure of incoming visitors to our State and the State implemented teleworking from home, to practice social distancing and slow the spread of COVID-19. HCOB was well equipped to quickly change work strategy to work from home, as we all have work laptops with VPN access to our KOLEA eligibility system and hotspots for Wi-fi connectivity.

HCOB must now conduct outreach in different ways and be creative in how we reach the community given our current environment of staying home and working from home. With so many or our residents being laid off and businesses closing due to COVID-19, our outreach team will need to be more available to residents to help educate them on their health care options with Med-QUEST as well as through the Federal Health Insurance Marketplace as well as assisting them to apply and enroll.

D. Complaints/Grievances

January 2020 – March 2020 Complaints/Grievances Received and Sorted by the Health Care Services Branch (HCSB) of MQD		
Total Calls Received by Description	**# Addressed by HCSB**	**# Addressed by Other Offices**
3 - Follow up calls regarding open State Grievance	3	
2 - Information regarding State Grievances and/or Appeals	1	1
3 - Denied services	2 1 – left voicemail no returned call	
1 - Resolution is incorrect/ not satisfied with resolution	1	
6 - Health plan, physician and/ or services	5	1
4 - Transportation	4	
8 - Customer Service and Eligibility		8
1 - Complaint against Hilopaa	1	
3 - Request for specific medication	3	
1 – Member billed and does not agree		1

All issues above have been addressed by various MQD staff who have knowledge in the specific subject areas.

E. Quality of Care

A review of dental procedures performed on children was conducted. We looked at the reimbursement rates for neighbor island dental providers versus Oahu providers and utilization. Data showed Oahu providers tended to do more fillings rather than putting on crowns. Claims data showed it appeared to be tied to reimbursements for

crowns as neighbor island providers were reimbursed more than Oahu providers. Therefore, to ensure children on Oahu received comparable care the rates for Oahu providers for specific codes has been adjusted.

Hawaii only covers emergency services for adults. The Division looked at potential benefits of having a full dental benefit for adults and different coverage options. In the study, in conjunction with the American Dental Association, different benefits for different populations, the associated costs and quality of care for recipients was reviewed. The study also looked at potential savings from unnecessary emergency room visits due to dental issues which impacts program costs, access to health care, health and well-being of recipients and, for the community, utilization of health care resources

[See EQRO information in section XI.]

F. Access that is Relevant to the Demonstration

There has been significant policy and operational work done around standing up the Community Integration Services (CIS) waiver for MQD's QUEST Integration population, with the goal of bringing Tenancy Support services to the recipients with the greatest needs for CIS. As a result of multiple meetings and discussions with agency providers, community advocates, managed care health plans, and other DHS staff, MQD issued a memo on March 6, 2020 that outlined specific data requirements regarding CIS enrollment and disenrollment. This memo lays the groundwork for capturing data required to report rapid cycle progress on our CIS efforts.

During the prior quarter, MQD hired a consultant, Corporation for Supportive Housing (CSH), to assist MQD on the implementation of CIS. Two tasks have been assigned to the consultants. The first is to help MQD with the policy setting and planning stages of CIS, and the second to develop a workflow/process mapping for a pilot Emergency room/Care coordination initiative with our largest trauma hospital in the state. The Queens' Emergency Department Initiative is a partnership with Queens' Hospital, QI MCOs, MQD & DHS staff, and community agency providers to provide intensive care coordination and case management for high utilizers of the Queen's ED. Weekly meetings between the consultant and key MQD staff have produced another comprehensive draft memo that describes how a member will be referred into CIS, the assessments and member consent process, and provider payment and procedure codes required.

G. 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.

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. Adverse Incidents

A. Medicaid Certified Nursing Facilities

Total of 11 reported adverse incident reports submitted during the period of January 2020 – March 2020.

- 6 unattended/unwitnessed falls
- 4 witnessed falls
- 1 physical injury

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 13 reported adverse incident reports submitted during the period of January 2020 - March 2020.

- 4 ER visits due to illness
- 1 ER visit due to physical Injury
- 2 ER visits due to seizures
- 2 ER visits due to UTI
- 1 ER visit for a foreign body in nose
- 1 ER visit for pressure wound
- 2 unwitnessed falls

B. Long Term Services and Supports (LTSS)

Due to new challenges and changes presented by the COVID-19 pandemic, some delays in reporting have occurred. As a result, complete information/data for this section is not available at this time.

V. 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 2nd 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 2.

1) A cross-cutting committee to address policy issues impacting encounter data was established, and monthly meetings of the committee were scheduled. The committee creates a structure that is set up to address ongoing encounter data challenges from various perspectives.
2) MQD also began planning for a funding request to implement encounter data validation supports to improve encounter data validation, processing, investigations, and support from AHCCCS.
3) Based on the identified need for additional training on coding, a class for employees across the division wishing to improve their skills with coding was held and covered topics ranging from ICD to CPT and HCPCS coding.
4) MQD launched a contract with its EQRO to conduct an external encounter data validation project. The project will include a full assessment of the Hawaii encounter pend system, including pend system edits; describe 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.

VI. Action Plans for Issues Identified In:

A. Policy

During the reporting period, there were several policy issues that required clarification to MQD staff and certain providers, which did not require corrective action. Implementation was completed going forward. These clarifications included treatment of a revocable transfer on death deed for long-term care eligibility, treatment of census worker income, and increase in the FPL limits and resource limits for the Medicaid programs.

B. Administration

Hawaii is currently in the process of procuring an Asset Verification System (AVS) vendor. In addition, a corrective action plan is being drafted and will be submitted to CMS next quarter to ensure the state is not cited for non-compliance for failure to implement the AVS timely.

C. Budget & Expenditure Containment Initiatives

There were no significant financial nor expenditure issues this quarter. Also, during the reporting period, an external review of MQD's CMS-64 reporting procedures began. MQD has not yet received any recommendations for procedural changes.

VII. Monthly Enrollment Reports for Demonstration Participants

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**1/2020 - 03/2020**	**1/2020 - 03/2020**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	342,260	113,185
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	100,386	33,053
Aged	Aged w/Medicare	83,964	28,379

	Aged w/o Medicare		
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	70,804	23,836
Expansion State Adults	Expansion State Adults	277,388	91,267
Newly Eligible Adults	Newly Eligible Adults	61,354	20,089
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,651	544
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)	89,501	29,273
Total		**1,027,308**	339,626

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	198,997
Title XXI funded State Plan	29,273
Title XIX funded Expansion	111,356
Enrollment current as of	3/31/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 03/31/20
EG 1 – Children	**114,973**	**114,947**	**113,991**	**343,911**

EG 2 – Adults	**33,520**	**33,683**	**33,183**	**100,386**
EG 3 – Aged	**27,831**	**27,987**	**28,146**	**83,964**
EG 4 – Blind/Disabled	**23,510**	**23,628**	**23,666**	**70,804**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**113,945**	**112,796**	**112,001**	**338,742**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 03/31/20
State Plan Children	**114,428**	**114,402**	**113,430**	**342,260**
State Plan Adults	**33,520**	**33,683**	**33,183**	**100,386**
Aged	**27,831**	**27,987**	**28,146**	**83,964**
Blind or Disabled	**23,510**	**23,628**	**23,666**	**70,804**
Expansion State Adults	**93,086**	**92,423**	**91,879**	**277,388**
Newly Eligible Adults	**20,859**	**20,373**	**20,122**	**61,354**
Optional State Plan Children	**0**	**0**	**0**	**0**
Foster Care Children, 19-20 years old	**545**	**545**	**561**	**1,651**
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.	**4,335**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**837**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,012**

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 as of May 2020 submissions]

Health Plan	Jan 2020	Feb 2020	Mar 2020
Aloha Care	538	525	644
HMSA	712	718	723
Kaiser	301	297	302
Ohana	2795	2708	2674
United Healthcare	2323	2210	2233
Total	**6669**	**6458**	**6576**

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

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

Member Choice of Health Plan Exercised

January 2020 – March 2020	Number of Members
Individuals who chose a health plan when they became eligible	**922**
Individuals who were auto-assigned when they became eligible	**6,850**
Individuals who changed their health plan after being auto-assigned	**2,395**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	[Information source unavailable at this time.]

Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**6**

During this reporting period, 922 individuals chose their health plan since they became eligible in the previous quarter, 2,395 changed their health plan after being auto-assigned. Also, 8,703 individuals had an initial enrollment which fell within this reporting period.

In addition, 6 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

IX. Member Grievances and Appeals, Filed during the Quarter, by Type

A. Grievances

During the FFY 2020 2nd quarter, Health Plans and MQD received and addressed the following number of member complaints/grievances.

Member Grievances to Health Plan			
	Jan- March 2020	Jan- March 2020	Jan- March 2020
Submitted	**QI**	**CCS**	**TOTAL**
Total number filed during the reporting period	262	20	282
Total number that received timely acknowledgement from health plan	258	18	276
Total number not receiving timely acknowledgement from health plan	4	2	6
Total number expected to receive timely acknowledgement during next reporting period	2	0	2
Total number that received timely decision from health plan	252	20	272
Total number not receiving timely decision from health plan	6	0	6
Total number expected to receive timely decision during next reporting period	6	0	6

Total number currently unresolved during the reporting period	9	0	9
Total number overturned	0	0	0

Due to challenges presented by the Covid-19 pandemic, one health plan requested a reporting extension. The table above contains information from 4 out of the 5 contracted health plans.

Types of Member Grievances to Health Plans			
	Jan- March 2020	Jan- March 2020	Jan- March 2020
Medical	**QI**	**CCS**	**TOTAL**
Provider Policy	3	0	3
Health Plan Policy	15	0	15
Provider/Provider Staff Behavior	43	0	43
Health Plan Staff Behavior	23	0	23
Appointment Availability	9	0	9
Network Adequacy/ Availability	0	0	0
Waiting Times (office, transportation)	82	7	89
Condition of Office/ Transportation	0	0	0
Transportation Customer Service	16	1	17
Treatment Plan/Diagnosis	15	0	15
Provider Competency	24	3	27
Interpreter	0	0	0
Fraud and Abuse of Services	1	0	1
Billing/Payments	16	1	17
Health Plan Information	18	2	20
Provider Communication	14	8	22
Member Rights	3	6	9

Some members had multiple areas that need to be addressed within their one grievance report to MQD.
Due to challenges presented by the Covid-19 pandemic, one health plan requested a reporting extension. The table above contains information from 4 out of the 5 contracted health plans.

Status of Member Grievances Addressed by the HCSB of MQD				
	January 2020	February 2020	March 2020	TOTAL
Submitted to HCSB to address	0	0	7	7
Health Plan resolved with Members	0	0	0	0

Dismiss as untimely filing	0	0	0	0
Member withdrew appeals	0	0	1	1
Resolution in Health Plan favor	0	0	1	1
Resolution in Member's favor	0	0	4	4
Still awaiting resolution	0	0	2	2
Carry-over from previous Quarter	6*	0	0	6*

*This contains a case carried over from 5/14/19 and is being addressed, in part, by the Med-QUEST Eligibility Branch. It involves issues related to bills for services not received by the member.

Types of Member Grievances Addressed by the HCSB of MQD				
	January 2020	February 2020	March 2020	TOTAL
Medical	0	0	0	0
Long Term Services and Support	0	0	0	0
Transportation	0	0	2	2
Applied Behavioral Analysis (ABA)	0	0	1	1
Durable Medical Equipment	0	0	0	0
Reimbursement	0	0	1	1
Medication	0	0	2	2
Miscellaneous	0	0	2	2

B. Appeals

Due to new challenges and changes presented by the COVID-19 pandemic, some delays in reporting have occurred. As a result, complete information/data for this section is not available at this time.

X. Demonstration Evaluation and Interim Findings

During FFY 2020 2nd Quarter, MQD's Health Analytics Office (HAO) continued to refine the draft evaluation design for the 2019-2024 1115 waiver. The UH team continued to work on a draft that included an overall evaluation along with in-depth evaluations of five key areas, including Community Integration Services, Home and Community Based Services, Social Determinants of Health, advancing primary care, and the evaluation of a quality area that is indicative of needing improvement, as identified during the previous demonstration period (childhood immunization status). Substantial feedback was provided by HAO staff to the UH team on the second draft; MQD staff provided detailed editing and support to ensure that the structure and program operations of MQD were described accurately. Towards the end of the FFY 2020 2nd Quarter, the UH staff submitted a third draft to HAO for review.

XI. Quality Assurance and Monitoring Activity

Quality Activities During the Quarter January to March 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)

January:

- On 01/27/20, received the FUH PIP Module 3 submission from HMSA.
- On 01/29/20, received the AWC PIP Module 4 plan from Ohana for pre-validation review.
- On 01/31/20, provided Module 3 validation tools to AlohaCare, HMSA, Kaiser, Ohana CCS, and UHC.

February:

- Provided PIP technical assistance to AlohaCare, HMSA, Kaiser, and Ohana.
- Received Module 3 resubmissions from HMSA (02/14/20), Kaiser (02/19/20), and Ohana (02/26/20).
- On 02/21/20, provided pre-validation review feedback to Ohana for the AWC PIP Module 4 plan.

March:

- Provided PIP technical assistance to HMSA (03/06/20), Ohana (03/16/20), and Kaiser (03/23/20).
- Received Module 3 resubmissions from Kaiser for the FUH PIP (03/03/20) and HMSA for the AWC and FUH PIPs (03/13/20).

- Reviewed the Module 3 resubmissions and provided validation tools to Kaiser (03/10/20) and HMSA (03/20/20).
- Reviewed Ohana FUH PIP and Ohana CCS FUH and FUM PIPs Module 3 resubmissions and provided validation tools on 03/03/20.
- Received Module 4 plans from AlohaCare for the AWC and FUH PIPs and UHC for the AWC and FUH PIPs on 03/13/20.
- Reviewed the AlohaCare Module 4 plans and provided pre-validation review feedback on 03/30/20.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

January:
- HSAG clarified and finalized with the MQD, questions regarding the SBIRT performance measure and specifications clarification on 01/8/20.
- The MQD submitted the sample frames for all QI plans to HSAG on 01/06/20.
- HSAG completed the survey sample frame validation and provided approvals to the QI health plans and MQD by 01/31/20.
- QI plans submitted the completed HEDIS 2020 Roadmap to HSAG by 01/31/20.

February:
- HSAG sent the final list of recommendations for 2020 to the MQD on 11/18/19. Sent the Convenience Sampling letters to the QI health plans on 02/07/20 and 02/10/20.
- Sent the non-HEDIS performance measure rate reporting template to the QI health plans on 02/28/20.

March:
- Finalized approval of all supplemental data (standard and non-standard) for AlohaCare, Kaiser, UHC, and ‘Ohana on 03/31/20.
- Finalized approval of all supplemental data (standard and non-standard) for HMSA on 04/03/20.
- Sent notification to the health plans on 04/03/20 to allow the option to rotate the hybrid measure rates with the audited HEDIS 2019 hybrid measure rates.

3. Compliance Monitoring

January:
- Completed review of all health plan 2019 CAPs. Provided feedback to the health plans. Due date for completion of all outstanding CAPs is 03/31/20.
- Received credentialing/recredentialing universes from all health plans on 01/17/20.
- Posted desk review form, EQR tool, and credentialing samples for all health plans in SAFE on 01/31/20.

February:
- Conducted 2020 compliance review technical assistance webinar for the health plans on 02/11/20.
- Received completed health plan documents (desk review form, EQR tool, and credentialing files) from AlohaCare, HMSA, Kaiser, and UHC CP on 02/28/20.

March:

- Received completed health plan documents (desk review form, EQR tool, and credentialing files) from Ohana QI and CCS on 03/03/20.
- Began reviewing health plan credentialing files and desk review documents.
- Informed health plans on 03/17/20 that the onsite compliance reviews scheduled for April would be postponed to a later date due to COVID-19.

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

January:

- Received 2020 sample frame files from the MQD on 01/06/20.
- HEDIS Auditors completed validation of the sample frame files on 01/27/20.

February:

- Received sample frame file for deduplication from UnitedHealthcare Community Plan on 02/05/20.
- Sent sample frames to subcontractor on 02/06/20.
- Sent the finalized survey mail materials for the Adult Medicaid QUEST Integration health plans and CHIP population to the MQD on 02/11/20.
- Selected survey samples on 02/12/20.
- Received and submitted sample frame file with additional samples for deduplication to AlohaCare on 02/14/20.
- Sent an updated timeline reflecting the final date that data for the health plans must be submitted to the CAHPS Health Plan Database to the MQD on 02/19/20.
- Ran survey samples through the U.S. Postal Service's National Change of Address (NCOA) system on 02/20/20.
- Printed and produced survey packets on 02/25/20.
- Mailed first questionnaires and cover letters to members on 02/26/20.

March:

- Mailed first postcard reminders to non-respondents on 03/04/20.
- Notified the MQD that a third mailing will replace CATI due to COVID-19 on 03/17/20.
- Sent an updated timeline reflecting the new survey administration protocol to the MQD on 03/23/20.
- Mailed second questionnaires and cover letters to non-respondents on 03/27/20.
- Sent weekly disposition reports to the MQD.

5. Provider Survey

January:

- No update for January

February:

- Provided the MQD with sampling plan used for 2018 survey administration for review and feedback on 02/28/20.

March:

- Received the MQD's approval to use the same 2018 sampling plan for this year's survey administration on 03/02/20.

6. Annual Technical Report

January:

- Received feedback on the technical report from the MQD on 01/03/20.
- Submitted final 508-compliant 2019 EQR technical report to the MQD on 01/15/20.
- Mailed eight technical reports to the MQD on 01/15/20,

February:

- No update at this time.

March:

- Began discussions with EQR activity leads on the technical report template.

7. Technical Assistance

January:

- Met with HAO to discuss PLD files on 01/09/20.

February:

- No update at this time.

March:

- Assisted the Health Analytics Office (HAO) with researching and answering several HEDIS measure specification questions posed by UHC CP.

XII. 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).

XIII. Other

Status of Current QUEST Integration Contract

Hawaii communicated with CMS on the QI RFP 12 on Pre-prints A-E and received approval on B-D in this quarter. In addition, Hawaii also communicated and responded with CMS on July to December 2018 and January to December 2019 adjustment rates in this quarter.

MQD continues to wait for final approval from CMS on QI RFP SC#12.

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.

In the current period, 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 staff completed all gap testing in the HOKU system in this quarter. Work has begun on implementation and communication plans in preparation for go-live. MQD communicated a memo to the MCOs and providers that included information about the go-live date at that time, registration in HOKU by waves, 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.

A variety of trainings have occurred between January – March 2020. The HOKU vendor, CNSI, conducted Train-the-Trainer sessions to train our MCO representatives. The MCOs have agreed to host the provider training sessions on behalf of MQD. CNSI also held State User Training sessions to train MQD and Koan staff who will be processing provider applications in HOKU. With the MCO representatives trained, we have held a few provider training sessions. However, we had to stop the in-person provider training sessions due to the PHE and decided to host webinar training sessions. After redoing the training schedule, we decided to postpone provider training sessions with the go-live date also being postponed. MQD is currently reworking the provider training schedule and will tentatively resume webinar-based training sessions in July 2020.

MQD hired a tech-writer to assist with a HOKU general orientation video, provider training videos, policies and procedures, a new paper provider enrollment form, and other web content. The tech-writer was able to work on

a few provider training videos and procedures, the new paper provider enrollment form and web content. We had a slight setback as our tech-writer resigned the end of February. MQD has been working with hiring other potential candidates to continue the work the previous tech-write has been working on.

A challenge MQD faced in at the beginning of the PHE was that our provider enrollment applications were paper based only and majority of our staff began tele-working. Our clerical staff has been working hard to scan 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, work on the provider training videos and procedures if no tech-writer is hired and continue to work on HOKU conversion error clean-ups. The new go-live date will tentatively be in August, and MQD will work on provider communications and updating the website once the date is confirmed.

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 2 (Q2), 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 Business Rules Workbook; which is the cornerstone for the EVV solution as it reflects all the business rules that are needed to support the EVV impacted programs and configure the EVV solution. The 3rd Party EVV vendor visit file specification was distributed and posted to Med-QUEST's EVV website. The Technical Specifications final approval occurred in the in January of 2020. The team baselined the EVV schedule in January but due to efforts and resources focusing on COVID-19 the completion date for EVV testing was delayed. As a result of testing being delayed the Go-Live was moved from September to December 2020.

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 projected in December of 2020.

JANUARY

During the month of January 2020, the AZ and HI EVV Project Teams continued to focus on finalizing the Technical Specifications, participating in focused workstreams that address training, outreach, support, device management, and certification. Additionally, the team finalized the update to the Change Management Plan and facilitated their first Change Advisory Board (CAB). One of the critical tasks addressed in January was working towards an Integrated Master Schedule that includes Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The team worked to refine and sync the schedules between the states and Sandata to ensure all of the dependencies are coordinated and the goal is to baseline the

schedule in February. Weekly Technical Review meetings were held with the MCOs and EVV vendor to ensure a smooth implementation. The Provider, Member, Authorization, Claims Validation, Alt EVV, Open EVV-EVV, Data Warehouse Export, and Plan of Care EVV Technical Specifications documents were approved. The EVV Training Plan was reviewed and approved with the EVV vendor.

FEBRUARY

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

MARCH

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

MQD Workshops and Other Events

Focus:	**Home and Community-Based Services Settings Requirements Modules 101 and 201**		
For:	**Adult Residential Care Home Association- Hawaii Island**		
Speaker	Aileen Manuel	**Location**	Aging and Disability Resources Hilo, Hawaii
Length	2.5 hours	**Date**	February 20, 2020
Attendees	Approximately 25		
Description	Module 101 provides individuals with an overview of the Medicaid HCBS final and how it applies in residential and non-residential settings. Module 201 focus on residential provider-owned/controlled settings and implementation of 42 CFR 441.301(c)(4)(i)-(v)		

Focus:	Dementia Friends		
For:	**Community Care Foster Family Homes (CCFFH)** **HCBS Medicaid Providers**		
Trainer	Dr. Ritabelle Fernandez	**Location**	Maui Adult Day Care Center
Length	2 hours per session	**Dates**	February 22, 2020- 1 session
Attendees	Approximately 40		
Description	An interactive session to learn about **dementia** and how it can affect people's lives. Caregiver tips for communicating and better managing challenging behaviors.		
Objectives/Outcomes	• Understand the warning signs and different stages of dementia. • Describe solutions to deal with difficult behaviors, including wandering. • Take action and pledge to becoming a Dementia Friend.		

A. Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for January 2020 – March 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 12/31/2019 is attached. The Budget Neutrality worksheet for the quarter ending 3/31/2020 will be submitted by the 5/31/2020 deadline.

B. MQD Contact(s)

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QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jan-20					Feb-20					Mar-20				
	AlohaCare	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**
# Members															
Medicaid	59,415	152,062	29,542	26,328	35,864	59,226	151,528	29,465	26,159	33,909	59,489	151,640	29,420	26,242	33,705
Duals	3,437	5,499	1,287	9,473	14,946	3,461	5,536	1,299	9,386	15,071	3,512	5,638	1,298	9,374	15,003
Total	**62,852**	**157,561**	**30,829**	**35,801**	**50,810**	**62,687**	**157,064**	**30,764**	**35,545**	**48,980**	**63,001**	**157,278**	**30,718**	**35,616**	**48,708**
# Network Providers															
PCPs	804	1,023	226	795	871	799	1,025	239	795	870	815	1,031	241	795	882
PCPs - (accepting new members)	676	798	213	578	633	671	805	227	578	634	688	813	228	578	643
Specialists	2,563	2,947	475	1,545	1,493	2,612	2,991	474	1,545	1,492	2,617	2,979	474	1,547	1,501
Specialists (accepting new members)	1,764	2,947	475	990	1,344	1,816	2,991	474	990	1,345	1,827	2,979	474	992	1,354
Behavioral Health	827	1,631	124	666	1,033	847	1,641	118	666	1,037	855	1,654	116	667	1,040
Behavioral Health (accepting new members)	739	1,631	124	626	998	757	1,641	118	626	1,001	762	1,654	116	627	1,004
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	47	37	17	38	34	48	37	16	38	34	48	37	16	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	569	626	139	1,036	1,194	574	627	109	1,036	1,197	588	628	123	1,040	1,196
HCBS Providers (except residential settings and LTSS facilities)	72	157	70	91	59	72	157	65	91	60	72	158	72	91	60
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,862	2,442	132	1,776	1,780	1,884	2,437	122	1,776	1,773	1,880	2,445	121	1,779	1,779
Total # of providers	**6,769**	**8,890**	**1,195**	**5,971**	**6,487**	**6,861**	**8,942**	**1,156**	**5,971**	**6,486**	**6,900**	**8,959**	**1,175**	**5,981**	**6,515**
Call Center															
# Member Calls	4,493	8,297	848	7,934	4,714	3,973	6,666	408	6,449	3,925	3,865	6,346	326	6,127	3,688
Avg. time until phone answered	0:00:08	0:00:08	0:00:10	0:00:23	0:00:22	0:00:09	0:00:16	0:00:14	0:00:21	0:00:16	0:00:08	0:00:18	0:00:09	0:00:56	0:00:15
Avg. time on phone with member	0:05:57	0:06:25	0:04:41	0:08:03	0:06:55	0:05:59	0:06:21	0:04:59	0:08:52	0:07:01	0:05:56	0:05:46	0:05:45	0:08:21	0:06:45
% of member calls abandoned (member hung up)	0.6%	0.1%	2.7%	3.0%	1.4%	1.0%	1.2%	2.0%	2.9%	0.9%	0.5%	1.6%	1.0%	2.6%	1.0%
# Provider Calls	8,215	5,649	70	3,509	3,618	7,284	5,314	68	3,177	3,004	7,205	5,380	73	2,827	2,854
Avg. time until phone answered	0:00:22	0:00:16	0:00:21	0:00:14	0:00:01	0:00:25	0:00:21	0:00:13	0:00:27	0:00:01	0:00:18	0:00:22	0:00:04	0:00:08	0:00:02
Avg. time on phone with provider	0:05:36	0:07:08	0:03:52	0:11:57	0:06:40	0:05:43	0:07:29	0:03:49	0:11:42	0:06:59	0:05:52	0:07:40	0:03:57	0:11:22	0:07:18
% of provider calls abandoned (provider hung up)	1.30%	1.45%	0.00%	2.56%	0.1%	1.66%	1.47%	0.00%	3.46%	0.1%	1.00%	1.95%	4.00%	1.70%	0.1%
Medical Claims- Electronic															
# Submitted, not able to get into system	2889	3,235	0	2,991	5,629	2171	1239	0	2,796	5,193	2760	1319	0	2,787	5,076
# Received	52,488	156,082	31,038	55,626	82,596	51,264	149,417	33,223	53,564	77,981	54,799	151,728	32,429	53,528	84,449
# Paid	44,272	152,582	28,333	47,000	78,683	50,835	133,613	32,055	46,222	71,276	54,236	137,618	29,598	44,876	77,776
# In Process	15,001	40,578	1,843	13,365	14,679	12,447	45,603	430	6,159	18,855	9,041	48,542	818	2,746	20,138
# Denied	2,235	11,974	862	5,832	8,763	3,392	10,741	738	9,350	7,395	3,511	11,171	2,013	9,631	8,637
Avg time for processing claim in days	6	10	1	9	10	8	9	1	6	7	5	9	1	6	8
% of electronic claims processed in 30 days	95.6%	97.3%	99.98%	98.1%	99.3%	94.7%	98%	99.97%	99%	98.9%	98.8%	98%	99.97%	100%	96.3%
% of electronic claims processed in 90 days	99.9%	99.8%	99.99%	99.86%	99.96%	94.9%	100%	99.98%	100%	99.98%	99.8%	100%	100%	100%	100%
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	266	902	0	236	690	309	724	3	115	718	530	1,239	5	94	792
# Received	11,893	16,421	28	5,036	8,202	10,485	16,186	24	5,168	7,151	15,544	15,972	33	5,167	7,310
# Paid	13,521	14,652	16	3,235	6,719	14,020	12,478	8	4,012	6,113	19,856	13,289	22	2,841	6,934
# In Process	5,174	8,464	1	1,847	3,302	6,796	9,993	12	611	3,859	5,814	10,235	0	266	2,981
# Denied	1,712	2,361	11	1,371	1,205	2,007	2,177	4	1,915	1,296	2,889	2,441	11	1,473	1,599
Avg time for processing claim in days	17	17	27	10	13	19	18	4	9	11	13	18	5	9	11
% of electronic claims processed in 30 days	96.3%	92.2%	88.9%	99.2%	98.9%	95.7%	93%	91.7%	99%	98.5%	96.5%	94%	100%	99%	94.2%
% of electronic claims processed in 90 days	99.4%	99.4%	96.3%	99.9%	99.85%	99.5%	99%	100%	100%	99.99%	99.2%	99%	100%	100%	99.99%
Prior Authorization (PA)- Electronic															
# Received	180	2,236	689	103	2,439	135	2152	626	110	2,120	147	1982	653	129	2,153
# In Process	35	362	20	92	0	21	447	38	94	0	27	339	17	125	164
# Approved	140	1,920	669	88	1,979	109	1,877	562	98	1,727	116	1,881	627	109	1,791
# Denied	13	237	0	4	252	15	190	26	6	232	14	209	9	31	198
Avg time for PA in days	2	4	4	2	3	2	5	2	3	3	1	5	3	4	1
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,705	507	0	1,765	88	1,531	495	0	1,746	63	1,557	477	0	1,727	55
# In Process	414	98	0	1,573	0	355	82	0	1,494	0	192	30	0	1,637	1
# Approved	1,228	449	0	1,550	79	1,140	461	0	1,655	52	1,296	493	0	1,854	44
# Denied	99	41	0	22	6	122	50	0	20	7	217	36	0	27	10
Avg time for PA in days	3	2	0	2	5	3	2	0	3	4	2	2	0	4	6
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3,124	5,885	492	6501	9,554	3,083	5,222	473	5449	9,171	3,295	5,410	430	5725	8,310
Air (by segment)	1,463	2,097	202	650	765	1,326	1,834	241	557	801	1,044	1,415	178	500	658
Public Transportation Pass (bus pass & handivan coupons)	1,994	1,127	714	2148	950	1,663	1,104	657	1938	876	1,084	1,152	300	1926	818
# Member Grievances															
# Received	12	9	19	33	44	20	10	13	22	40	20	6	11	23	30
# Resolved	11	6	13	25	24	17	11	20	10	42	22	9	10	15	40
# Outstanding	10	9	14	8	23	13	8	7	12	21	11	5	8	8	11
# Provider Grievances															
# Received	124	0	1	3	0	132	2	2	0	0	166	0	0	4	0

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jan-20					Feb-20					Mar-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Resolved	41	0	1	2	0	11	0	2	1	0	48	0	0	2	0
# Outstanding	497	0	0	1	0	620	2	0	0	0	738	2	0	2	0
# Member Appeals															
# Received	8	130	0	7	13	7	50	0	4	9	4	72	2	3	14
# Resolved	8	116	0	9	15	8	72	0	9	11	6	60	0	2	8
# Outstanding	8	43	0	7	11	7	21	0	3	9	5	33	0	4	15
# Provider Appeals															
# Received	22	5	0	64	131	50	18	0	109	91	49	29	0	52	89
# Resolved	19	13	0	105	101	1	11	0	138	123	7	23	0	44	113
# Outstanding	97	16	0	48	75	146	23	0	17	43	188	29	0	24	19
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	80	81	4	134	243	65	72	4	128	177	63	56	4	117	172
Inpatient Acute Days * (A) - per 1,000	424	243	22	869	755	346	205	20	595	618	333	166	18	506	658
Readmissions within 30 days* (A)	47	148	26	45	38	42	104	24	34	41	44	83	15	40	27
ED Visits * (C) - per 1,000**	605	476	27	881	670	597	460	34	796	550	512	374	25	701	586
# Prescriptions (C) - per 1,000	8,793	10,619	671	46,970	13,359	8,663	10,140	634	12,130	13,883	9,232	10,762	716	13,500	14,659
Waitlisted Days * (A) - per 1,000	54	0	5	181	149	69	4	2	112	144	60	5	2	89	120
NF Admits * (A)	50	17	3	0	15	43	11	5	2	12	32	13	3	1	17
# Members in NF (non-Medicare paid days) (C)**	241	242	70	729	895	212	253	68	695	821	245	257	69	673	921
# Members in HCBS **(C)- note: member can be included in more than one category listed below	297	470	231	2066	1,428	313	465	229	2013	1,389	399	466	233	2001	1,312
# Members in Residential Setting **(C)	141	115	140	558	869	118	110	141	541	881	153	114	142	494	896
# Members in Self-Direction **(C)	82	176	40	783	335	82	171	39	741	296	82	171	43	740	246
# Members receiving other HCBS **(C)	159	355	191	1283	224	201	357	190	1272	213	246	354	190	1261	170
# Members in At-Risk ** (C)	641	551	112	851	979	650	578	116	749	952	668	591	117	788	1,017
# Members in Self-Direction **(C)	280	237	35	430	546	282	242	30	394	546	296	254	30	397	598
# Members receiving other HCBS **(C)	186	531	77	457	433	297	566	86	455	406	299	565	87	408	419

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

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: 3/31/2020

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	464	83	19	13	64	79	93	815
PCPs - (accepting new members)	**387**	**71**	**16**	**11**	**54**	**66**	**83**	**688**
Specialists*	1,947	216	25	0	175	72	182	2,617
Specialists (accepting new members)	**1,362**	**145**	**11**	**0**	**117**	**51**	**141**	**1,827**
Behavioral Health*	534	116	11	2	47	80	65	855
Behavioral Health (accepting new members)	**463**	**108**	**11**	**2**	**44**	**76**	**58**	**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)	484	27	1	0	9	52	15	588
HCBS Providers (except residential settings and LTSS facilities)	34	11	3	3	6	10	5	72
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,219	222	24	13	141	124	137	1,880
Totals	**4,722**	**680**	**84**	**33**	**451**	**424**	**506**	**6,900**

* 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	35,599	7,959	2,227	441	5,095	6,010	5,670	**63,001**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	77	96	117	34	80	76	61	77

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)*	645	89	14	15	63	99	106	1,031
PCPs - (accepting new members)	**490**	**67**	**12**	**10**	**49**	**86**	**99**	**813**
Specialists*	1,804	288	68	38	180	286	315	2,979
Specialists (accepting new members)	**1,804**	**288**	**68**	**38**	**180**	**286**	**315**	**2,979**
Behavioral Health*	1,029	196	9	6	90	187	137	1,654
Behavioral Health (accepting new members)	**1,029**	**196**	**9**	**6**	**90**	**187**	**137**	**1,654**
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)	500	29	1	0	10	67	21	628
HCBS Providers (except residential settings and LTSS facilities)	73	20	9	6	16	24	10	158
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,590	259	32	22	171	162	209	2,445
Totals	**5,680**	**885**	**135**	**88**	**536**	**831**	**804**	**8,959**

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

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	91,650	10,877	846	152	10,419	26,154	17,180	**157,278**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	142	122	60	10	165	264	162	153

Note: RFP requirement is 300 members for every PCP

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	175	66						241
PCPs - (accepting new members)	**170**	**58**						**228**
Specialists*	384	90						474
Specialists (accepting new members)	**384**	**90**						**474**
Behavioral Health*	97	19						116
Behavioral Health (accepting new members)	**97**	**19**						**116**
Hospitals	10	2						12
LTSS Facilities (Hosp./NF)	15	1						16
Residential Setting (CCFFH, E-ARCH, and ALF)	111	12						123
HCBS Providers (except residential settings and LTSS facilities)	53	19						72
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	91	30						121
Totals	**936**	**239**	**0**	**0**	**0**	**0**	**0**	**1,175**

* 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	20,321	10,397						**30,718**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	116	158	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	127

Note: RFP requirement is 300 members for every PCP

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# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	542	49	9	10	72	68	45	795
PCPs - (accepting new members)	**401**	**32**	**9**	**10**	**58**	**33**	**35**	**578**
Specialists*	1,166	107	13	4	113	75	69	1,547
Specialists (accepting new members)	**707**	**88**	**13**	**4**	**53**	**66**	**61**	**992**
Behavioral Health*	464	49	4	0	34	72	44	667
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)	873	41	0	0	18	83	25	1,040
HCBS Providers (except residential settings and LTSS facilities)	51	8	2	0	4	20	6	91
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,119	180	15	6	131	172	156	1,779
Totals	**4,249**	**439**	**45**	**22**	**380**	**493**	**353**	**5,981**

* 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	22,465	3,585	405	94	1,836	4,493	2,738	**35,616**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	41	73	45	9	26	66	61	45

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)*	570	63	10	4	59	71	54	831
PCPs - (accepting new members)	**437**	**28**	**6**	**3**	**51**	**46**	**33**	**604**
Specialists*	1,160	153	60	7	111	140	124	1,755
Specialists (accepting new members)	**1,037**	**139**	**47**	**7**	**103**	**124**	**113**	**1,570**
Behavioral Health*	757	236	61	63	158	235	191	1,701
Behavioral Health (accepting new members)	**730**	**233**	**61**	**63**	**154**	**231**	**186**	**1,658**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	25	2	0	0	3	4	1	35
Residential Setting (CCFFH, E-ARCH, and ALF)	982	55	2	0	24	110	23	1,196
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	1,287	242	15	8	138	178	149	2,017
Totals	**4,836**	**765**	**150**	**83**	**504**	**760**	**550**	**7,648**

* 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	32,568	3,911	250	87	2,472	6,217	3,203	**48,708**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	57	62	25	22	42	88	59	59

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls

as of: 3/31/2020

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	49	7	0	3	0	3	0	**62**
Network (provider look up, access)	44	7	0	0	3	12	2	**68**
Primary Care Physician Assignment or Change	106	16	2	0	6	20	5	**155**
NEMT (inquiry, scheduling) -*monthly repor*t	193	40	15	5	19	41	13	**326**
Authorization/Notification (prior auth status)	245	51	7	2	23	34	17	**379**
Eligibility (general plan eligiblity, change request)	254	31	3	0	17	24	13	**342**
Benefits (coverage inquiry)	91	12	1	1	11	10	4	**130**
Enrollment (ID card request, update member information)	27	1	0	0	2	5	1	**36**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	124	8	1	1	7	20	4	**165**
Billing/Payment/Claims	304	30	9	1	10	15	14	**383**
Appeals	4	0	0	0	0	0	0	**4**
Complaints and Grievances	0	0	0	0	0	0	0	**0**
Other	131	17	1	0	6	14	5	**174**
Totals	**1,572**	**220**	**39**	**13**	**104**	**198**	**78**	**2,224**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	18	6	0	0	6	7	4	**41**
Network (provider look up, access)	65	9	1	0	4	5	14	**98**
Primary Care Physician Assignment or Change	1,060	82	8	1	124	183	246	**1,704**
NEMT (inquiry, scheduling) -*monthly repor*t	0	0	0	0	0	0	0	**0**
Authorization/Notification (prior auth status)	21	2	0	0	2	9	10	**44**
Eligibility (general plan eligiblity, change request)	510	74	7	2	52	105	104	**854**
Benefits (coverage inquiry)	96	19	3	0	15	34	14	**181**
Enrollment (ID card request, update member information)	495	60	1	1	60	115	86	**818**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	29	10	1	0	1	7	15	**63**
Billing/Payment/Claims	135	34	2	1	23	21	22	**238**
Appeals	0	0	0	0	0	0	0	**0**
Complaints and Grievances	4	4	0	0	0	3	3	**14**
Other	336	62	7	0	29	76	75	**585**
Totals	**2,769**	**362**	**30**	**5**	**316**	**565**	**593**	**4,640**

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KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	0	0						**0**
Network (provider look up, access)	18	8						**26**
Primary Care Physician Assignment or Change	4	1						**5**
NEMT (inquiry, scheduling) -*monthly repor*t	11	0						**11**
Authorization/Notification (prior auth status)	0	0						**0**
Eligibility (general plan eligiblity, change request)	104	29						**133**
Benefits (coverage inquiry)	80	5						**85**
Enrollment (ID card request, update member information)	12	3						**15**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	17	13						**30**
Appeals	1	0						**1**
Complaints and Grievances	0	0						**0**
Other	82	11						**93**
Totals	**329**	**70**	**0**	**0**	**0**	**0**	**0**	**399**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	378	64	10	1	9	134	42	**638**
Network (provider look up, access)	16	2	0	0	2	4	3	**27**
Primary Care Physician Assignment or Change	94	6	4	0	7	19	9	**139**
NEMT (inquiry, scheduling) -*monthly repor*t	1,584	367	51	27	3	37	7	**2,076**
Authorization/Notification (prior auth status)	10	23	14	2	9	58	14	**130**
Eligibility (general plan eligiblity, change request)	65	10	1	0	1	18	4	**99**
Benefits (coverage inquiry)	114	9	3	0	6	21	14	**167**
Enrollment (ID card request, update member information)	260	20	9	2	14	72	16	**393**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	103	14	6	0	3	22	11	**159**
Billing/Payment/Claims	21	6	1	0	0	2	3	**33**
Appeals	8	1	1	0	1	5	2	**18**
Complaints and Grievances	10	2	0	0	0	5	2	**19**
Other	921	117	20	3	45	200	96	**1,402**
Totals	**3,584**	**641**	**120**	**35**	**100**	**597**	**223**	**5,300**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	167	31	0	2	20	28	27	**275**
Network (provider look up, access)	89	17	0	0	9	24	3	**142**
Primary Care Physician Assignment or Change	427	58	3	1	33	86	70	**678**
NEMT (inquiry, scheduling) -*monthly repor* t	57	9	2	0	10	16	11	**105**
Authorization/Notification (prior auth status)	32	17	3	0	15	37	10	**114**
Eligibility (general plan eligiblity, change request)	447	82	2	1	32	90	47	**701**
Benefits (coverage inquiry)	578	99	1	0	46	157	44	**925**
Enrollment (ID card request, update member information)	98	14	4	0	6	32	7	**161**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	102	18	1	0	6	24	10	**161**
Billing/Payment/Claims	11	1	0	0	0	0	0	**12**
Appeals	7	2	0	0	0	3	1	**13**
Complaints and Grievances	7	1	0	0	0	2	0	**10**
Other	271	47	1	0	12	50	23	**404**
Totals	**2,293**	**396**	**17**	**4**	**189**	**549**	**253**	**3,701**

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

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

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

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

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

Budget Neutrality Summary

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

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

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 693,404,469	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,546,121	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 464,444,505	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	501,847	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 639,049,304	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	329,548	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 836,728,258	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	316,133	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,633,626,537**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,660**	**$ 14,509,756,770**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 355,432,879	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,495,348,356
EG 2 - Adults	2		$ 162,273,934	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,169,877,415
EG 3 - Aged	3		$ 378,995,633	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,171,336,632
EG 4 – Blind/Disabled	4		$ 485,759,733	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,179,144,338
TOTAL			**$ 1,382,462,179**	**$ 1,647,483,577**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,464,550,364**

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	$ 355,432,879	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 337,971,590	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 253,478,693	$ 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	$ 162,273,934	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 302,170,571	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 226,627,928	$ 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	$ 378,995,633	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 260,053,671	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 195,040,253	$ 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	$ 485,759,733	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 350,968,525	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 263,226,394	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 938,373,269**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,533,904,805**

BASE VARIANCE			**$ 312,791,090**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,511,301,602**
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								**$ 1,511,301,602**

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)			$ 1,695,253,269	$ 3,621,160,670	$ 5,640,076,825	$ 7,756,670,683	$ 9,975,851,966	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,905,065	$ 54,317,410	$ 56,400,768	$ 38,783,353	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (312,791,090)	$ (591,214,914)	$ (883,299,928)	$ (1,189,749,175)	$ (1,511,301,602)	
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		$612,884,645	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 612,884,645**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,303,104,572**

HYPOTHETICALS VARIANCE 1			**$ 758,772,715**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,651,329,661**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ 2,132,568	$ 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	$1,429.15	
		Mem-Mon	1,800	3,782	3,877	3,974	4,073	
TOTAL			**$ 2,132,568**	**$ 4,695,845**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 23,113,513**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ 2,075,040	$ 4,569,466	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ 2,075,040**	**$ 4,569,466**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 22,489,730**

HYPOTHETICALS VARIANCE 2			**$ 57,528**	**$ 126,379**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 623,783**

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**	$ 5,816,106	$ 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	$3,897.67	
		Mem-Mon	1,800	3,782	3,877	3,974	4,073	
TOTAL			**$ 5,816,106**	**$ 12,806,873**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 63,036,828**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ 5,659,200	$ 12,462,181	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ 5,659,200**	**$ 12,462,181**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 61,335,627**

HYPOTHETICALS VARIANCE 3			**$ 156,906**	**$ 344,692**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,701,201**