Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: December 23, 2015

Demonstration/Quarter Reporting Period:
Demonstration Year: 21 (7/1/2015-9/30/2015)
Federal Fiscal Quarter: 4/2015 (7/1/2015-9/30/2015)
State Fiscal Quarter: 1/2015 (7/1/2015-9/30/2015)
Calendar Year: 3/2015 (7/1/2015-9/30/2015)

Introduction

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

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

The State's goals in the demonstration are to:

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

Enrollment Information

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

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 7/2015-9/2015	Unduplicated Members 7/2015-9/2015
Mandatory State Plan Groups			
State Plan Children	State Plan Children	365,580	115,964
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	122,520	38,865
Aged	Aged w/Medicare Aged w/o Medicare	73,771	24,546
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	74,157	24,501
Expansion State Adults	Expansion State Adults	210,905	65,562
Newly Eligible Adults	Newly Eligible Adults	103,581	33,457
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,239	422
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults	0	0
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group	-12	4
Total		951,741	303,321

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	239,287
Title XXI funded State Plan	26,969
Title XIX funded Expansion	99,018
Enrollment current as of	9/30/2015

Outreach/Innovative Activities

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

line at its mybenefits.hawaii.gov website.

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

Operational/Policy Developments/Issues

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

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

The MQD held an information session on State Transition Plan for the new Home and Community Based Services (HCBS) Federal Rules on July 30, 2015. MQD held two sessions, from 9:30a to 11:30a and 1:00p to 3:00p, to accommodate the participants receiving HCBS services and HCBS providers and other interested parties. The information session was held at the Hawaii State Laboratory in Pearl City on Oahu. The Hawaii State Laboratory has access to video teleconference (VTC) for streaming information to Kapolei on Oahu and other islands included Kauai, Maui and Hawaii. Updates and new information regarding the State Transition Plan was presented to the attendees. The attendees were also given an opportunity to provide input on the new requirements and the assessment component of the State Transition Plan.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

A. For Use in Budget Neutrality Calculations

This member month reporting related to the budget neutrality for fourth quarter of FFY15 will be submitted in the future.

B. For Informational Purposes Only

This member month reporting related to the budget neutrality for fourth quarter of FFY15 will be submitted in the future.

QUEST Integration Consumer Issues

HCSB Grievance

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

	Member		Provider	
	QI	FFS	QI	FFS
July 2015	26	2	3	1
August 2015	22	1	0	0
September 2015	10	0	1	0
Total	58	3	4	1

Appeals	Member #
Submitted	47
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	6
Member withdrew hearing request	1
Resolution in DHS favor	0
Resolution in Member's favor	0
Still awaiting resolution	0

During the fourth quarter of FFY15, the HCSB staff, as well as other MQD staff, processed approximately 64 member and provider telephone calls and e-mails (see table above). The number of calls from members is in line with past quarters. In previous quarters, MQD received approximately 55 to 60 calls, letters, and e-mails.

CSB Appeals

The HCSB received seven (7) member appeals in the fourth quarter of FFY15. DHS resolved six of the appeals with the health plans in the member's favor prior to going to hearing. One (1) DHS is still awaiting the results.
Of the seven (7) appeals filed, the types of appeals were medical (4), LTSS (1), medication (1) and overpayment (1).

Types of Member Appeals	#
Medical	4
LTSS	1
Other: Medications	1
Overpayment	1

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

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

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

Enrollment of individuals

The DHS had an increase of enrollment of approximately 11,870 members during the fourth quarter of FFY15. Of this group, 207 chose their health plan when they became eligible, 2,810 changed their health plan after being auto-assigned.

In addition, DHS had 210 plan-to-plan changes during the fourth quarter of FFY15. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 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.

	#
Individuals who chose a health plan when they became eligible	207
Individuals who changed their health plan after being auto-assigned	2,810
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	210
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	6

Long-Term Services and Supports (LTSS)

HCBS Waiting List

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

HCBS Expansion and Provider Capacity

During the fourth quarter of FFY15, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring long-term services and supports continues to increase. In the fourth quarter of FFY15, the increase is 34% since the start of the program receiving long-term services and supports. The number of individuals in nursing facilities increased this past quarter. HCBS usage has more than doubled since the start of the bringing the aged, blind, and disabled population into managed care (formerly QUEST Expanded Access (QExA), currently QUEST Integration). Nursing facility services have decreased by approximately 23.8% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 112% since program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving long-term care services. This number has increased to 66% (66.3%) since the start of the program.

	2/1/09	3rd Qtr FFY15, av	4rd Qtr FFY15, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 4th Qtr FFY15
HCBS	2,110	4,548	4,466	111.7%↑	42.6%	66.3%↑
NF	2,840	2,314	2,165	23.8%↓	57.4%	33.7%↓

Total	4,950	6,862	6,631	34%↑		

Behavioral Health Programs Administered by the DOH and DHS

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

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

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

QUEST Integration transition

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

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

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

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

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

Quality Assurance/Monitoring Activity

MQD Quality Strategy

Our goal continues to ensure that our clients receive high quality care by providing effective oversight of

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

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

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

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015, and subsequently submitted a revised draft quality strategy on September 30, 2015. MQD is currently awaiting further comments from CMS. The revised quality strategy is consistent with the previously approved 2010 version.

Quality Activities During The Quarter

The External Quality Review Organization (EQRO) oversees the health plans for the 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) –

- Prepared and submitted draft PIP reports to the MQD for review on 9/1/15.
- The final approved PIP reports were posted on 9/30/15.
- Mid-October 2015, reviewed the revised Modules 1 and 2 from one health plan that required follow-up and provided feedback.
- Continued to provide PIP technical assistance as requested by the health plans during their completion of Module 4.
- Currently reviewing the health plans' Module 4 updates in December 2015.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –

- Discussed HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) alignment with NCQA and the MQD to ensure alignment with accreditation standards.
- Provided sample methodology that would allow HEDIS and CAHPS to align, while also allowing the MQD to have results at the ABD and Non-ABD levels.
- Forwarded HEDIS 2016 Roadmap to health plans on 10/9/15 upon release from NCQA.
- Conducted webinar with health plans (10/26/15 & 10/27/15) and states (10/28/15) to review updates for HEDIS 2016.

- Activities completed for HEDIS 2015.
- Continue to provide technical assistance to the health plans and the MQD as needed.

3. Compliance Monitoring –
   No update at this time.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
- Submitted final Child Medicaid Aggregate and Plan-Specific CAHPS Reports and the final Children's Health Insurance Program (CHIP) Report to the MQD on 9/9/15.
- Activities completed for the 2015 CAHPS Survey administration.
- For 2016 CAHPS survey planning and preparation, begin preparing 2016 CAHPS survey materials and items for submission to the MQD.
- Preparing survey notification letter with data submission and administrative requirements.
- Preparing text for cover letters and postcards.
- Submitted notification letter, administrative forms, and sample frame file creation instructions to the MQD by 11/17/15. Also, submitted text for cover letters and postcards to the MQD for review and approval by 11/17/15.

5. Provider Survey –
- Began production of the draft Provider Survey Report.
- Incorporated survey data analysis into the draft Provider Survey Report.
- Performed internal review and validation of the draft Provider Survey Report.
- Submitted draft Provider Survey Report to the MQD on 10/5/15.
- Receives the MQD's feedback on the draft Provider Survey Report on 10/19/15.
  Responded to the MQD's feedback regarding island-level analysis for the Provider Survey.
- Submit final Provider Survey Report electronically to the MQD by 11/6/15.
  Mail the MQD one printed hard copy of the final Provider Survey Report by 11/7/15.

6. Annual Technical Report –
- Submitted the draft 2015 Annual Technical Report to the MQD on 10/21/15 for review.
- The EQRO issued the final 2015 External Quality Review Report of Results for the QI Health Plans and the CCS Program to MQD on 11/24/15.

On 11/27/15 the MQD posted the 2015 Annual Technical Repot to its website for the public and the health plans to review.

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

Demonstration Evaluation
MQD submitted its QUEST Integration Draft Evaluation Design to CMS on December 18, 2014. CMS responded with comments on September 9, 2015. The MQD has reviewed the CMS comments and had concerns about a few items. During a Quarterly 1115 Waiver Monitoring Call on October 21, 2015 the

MQD shared that there were a few concerns and requested an extension on the existing deadline of November 9, 2015. CMS agreed on an extended deadline, and that a new deadline will be determined after a pending conference call to discuss these concerns. The list of concerns was sent to CMS on November 12, 2015.

Enclosures/Attachments

Attachment A QUEST Integration Dashboard for July 2015 – September 2015

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Date Submitted to CMS

December 23, 2015

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jul-15					Aug-15					Sep-15				
	AlohaCare	**HMSA**	**Kaiser**	**Ohana**	**United**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**United**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**United**
# Members															
Medicaid	65,136	152,488	28,539	28,239	24,459	65,439	152,827	28,724	28,566	25,063	65,851	153,256	28,768	29,071	25,614
Duals	838	1,147	389	13,833	15,667	813	1,205	404	13,826	15,623	851	1,258	401	13,760	15,527
Total	**65,974**	**153,635**	**28,928**	**42,072**	**40,126**	**66,252**	**154,032**	**29,128**	**42,392**	**40,686**	**66,702**	**154,514**	**29,169**	**42,831**	**41,141**
# Network Providers															
PCPs	448	642	0	694	954	450	643	0	793	952	456	782	210	797	992
PCPs - (accepting new members)	288	489	0	420	840	289	489	0	526	837	294	523	203	530	877
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)	136	142	203	105	40	135	148	206		40					
PCPs - # in Clinics (accepting new members)	128	36	196	105	40	127	40	195		40					
Specialists	2,301	2,188	352	1,524	1,598	2,319	2,249	362	1,525	1,605	2,345	2,313	359	1,531	1,605
Specialists (accepting new members)	1,050	2,188	352	961	1,562	1,067	2,249	362	963	1,569	1,089	2,313	359	964	1,569
Behavioral Health	712	1,318	61	638	808	713	1,336	61	640	827	711	1,356	63	643	829
Behavioral Health (accepting new members)	536	1,318	61	581	796	538	1,336	61	616	815	537	1,356	63	619	818
Hospitals	26	26	14	24	24	26	26	14	24	24	26	26	14	24	24
LTSS Facilities (Hosp w/ NF unit/NF)	46	34	16	38	34	46	34	16	38	34	46	34	16	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	355	507	343	989	1,117	360	511	322	1,043	1,127	370	523	324	1,046	1,131
HCBS Providers (except residential settings and LTSS facilities)	42	145	38	143	44	44	121	37	90	44	48	123	39	90	44
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,585	1,742	108	1,740	935	1,575	1,777	107	1,767	936	1,577	1,803	107	1,777	936
Total # of providers	**5,651**	**6,744**	**1,135**	**5,895**	**5,554**	**5,668**	**6,845**	**1,125**	**5,920**	**5,589**	**5,579**	**6,960**	**1,132**	**5,946**	**5,595**
Call Center															
# Member Calls	3,651	7,759	528	10,394	4,698	4,428	6,934	582	9,975	4,250	4,237	6,907	676	10,918	4,401
Avg. time until phone answered	0:00:24	0:00:11	0:00:13	0:00:31	0:00:19	0:00:57	0:00:06	0:00:13	0:00:36	0:00:14	0:00:16	0:00:10	0:00:15	0:00:36	0:00:21
Avg. time on phone with member	0:04:40	0:05:04	0:03:17	0:08:00	0:05:21	0:04:46	0:04:51	0:03:30	0:09:00	0:05:18	0:04:11	0:04:56	0:03:14	0:09:21	0:05:47
% of member calls abandoned (member hung up)	4%	1%	3%	3%	1.8%	11%	1%	1%	4%	1.3%	4%	1%	1%	5%	2.0%
# Provider Calls	8,325	8,246	125	4,839	3,598	9,362	7,447	239	4,666	3,462	8,880	6,928	145	4,548	3,365
Avg. time until phone answered	0:00:24	0:01:29	0:00:06	0:01:00	0:00:11	0:00:58	0:01:28	0:00:12	0:01:05	0:00:04	0:00:16	0:01:21	0:00:13	0:00:56	0:00:06
Avg. time on phone with provider	0:04:30	0:04:26	0:02:31	0:08:00	0:05:31	0:04:40	0:04:48	0:02:30	0:08:00	0:05:54	0:04:40	0:05:18	0:02:25	0:07:59	0:05:54
% of provider calls abandoned (provider hung up)	4%	7%	2%	8%	0.69%	11%	7%	2%	7%	0.72%	3%	7%	3%	5%	0.65%
Medical Claims- Electronic															
# Submitted, not able to get into system	409	1,614		6,791	878	377	1,444		4,437	1,062	1,959	1,668		4,092	
# Received	37,381	125,451	731	71,801	43,902	37,617	123,875	752	68,696	53,110	41,745	133,573	981	68,653	44,970
# Paid	36,286	130,603	576	50,124	50,120	36,021	109,785	495	49,758	50,179	35,640	110,960	818	47,232	46,288
# In Process	6,275	32,742	119	14,090	7,271	5,451	41,251	234	14,048	16,569	9,784	58,343	98	16,623	13,701
# Denied	1,819	7,220	36	7,587	1,645	2,103	5,581	23	4,890	1,646	1,469	5,521	65	4,798	1,727
Avg time for processing claim in days	5	9	2	6	9	5	9	2	6	10	5	9	3	5	10
% of electronic claims processed in 30 days											99%	98%	100%	100%	99%
% of electronic claims processed in 90 days											100%	100%	100%	100%	99%
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	267	1,348		326	354	223	1,241		376	452	352	1,115		436	
# Received	19,391	19,886	424	14,770	17,717	17,145	20,679	399	14,782	22,607	18,593	18,067	466	15,112	24,588
# Paid	18,353	20,917	318	8,837	20,581	15,865	16,393	277	8,329	20,702	17,146	15,884	293	8,412	23,508
# In Process	5,309	7,000	72	2,663	2,545	3,779	9,700	93	3,999	7,499	5,968	10,466	131	3,834	7,455
# Denied	2,495	2,205	34	3,270	267	2,523	1,586	29	2,454	268	2,092	1,417	42	2,866	325
Avg time for processing claim in days	9	13	6	8	8	8	12	7	8	9	13	12	9	7	9
% of electronic claims processed in 30 days											97%	95%	99%	100%	98%
% of electronic claims processed in 90 days											100%	99%	100%	100%	99%
Prior Authorization (PA)- Electronic															
# Received	99	492	471	181	38	44	448	469	142	32	7	386	459	146	41
# In Process	22	150	0	3	0	14	128	0	5	0	0	67	0	12	4
# Approved	77	454	462	176	32	30	409	459	142	30	7	397	446	139	37
# Denied	0	62	9	11	6	0	61	10	0	2	0	50	13	6	0
Avg time for PA in days	6	10	3	3	4	6	9	8	2	3	11	9	10	2	4
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,534	760	0	1,668	2,838	1,095	655	0	1677	2,667	1,677	610	0	1,787	2,512
# In Process	139	1	0	113	33	223	2	0	230	43	248	2	0	379	64
# Approved	1,382	550	0	1,796	2,509	867	461	0	1597	2,324	1,427	443	0	1,723	2,188
# Denied	13	209	0	106	296	5	193	0	80	300	2	167	0	71	260
Avg time for PA in days	3	0	0	6	3	4	0	0	4	2	7	0	0	6	7
(month-to-date)															

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jul-15					Aug-15					Sep-15				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United
# Non-Emergency Transports															
Ground (# of round trips)	939	881	99	9,990	8,664	922	982	60	9556	8,459	577	940	54	9,756	8,545
Air (by segment)	541	663	3	1,222	382	634	752	0	1101	422	1,327	1,484	1	1,122	409
Public Transportation Pass (bus pass & handivan coupons)											133	5	52	1,244	1,134
# Member Grievances															
# Received	50	14	12	46	67	42	13	7	50	53	42	10	10	51	50
# Resolved	41	12	8	37	74	43	12	10	58	59	40	13	14	43	66
# Outstanding	18	11	7	36	23	17	12	4	28	17	19	9	0	36	1
# Provider Grievances															
# Received	6	0	0	2	0	3	0	0	3	2	3	0	0	0	0
# Resolved	4	1	0	1	2	3	0	0	2	1	11	0	0	4	1
# Outstanding	9	0	0	3	0	9	0	0	4	1	1	0	0	0	0
# Member Appeals															
# Received	1	33	0	4	14	3	37	0	7	6	0	41	0	4	12
# Resolved	0	32	2	2	10	3	32	0	4	6	2	32	0	11	11
# Outstanding	2	14	0	4	13	2	19	0	7	7	0	28	0	0	8
# Provider Appeals															
# Received	0	2	0	25	52	0	2	0	62	80	0	2	0	71	99
# Resolved	0	11	0	9	109	0	3	0	24	37	0	0	0	20	50
# Outstanding	0	2	0	45	69	0	1	0	83	112	0	3	0	134	161
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	88	164	4	139	173	83	183	3	141	171	85	197	3	142	134
Inpatient Acute Days * (A) - per 1,000	385	413	16	826	739	842	466	14	848	753	339	484	13	499	590
Readmissions within 30 days* (A)	39	263	13	99	38	40	261	7	92	29	41	347	12	79	35
ED Visits * (C) - per 1,000**	568	440	21	830	737	568	493	689	811	608					
# Prescriptions (C) - per 1,000	8,240	9,342	667	13,717	13,802	8,127	9,469	660	13,773	13,714	7,314	9,686	729	13971	13,544
Waitlisted Days * (A) - per 1,000	27	0	0	64	21	32	0	1	50	18	31	0	1	18	12
NF Admits * (A)	13	15	1	3	3	13	12	2	3	8	17	12	1	10	9
# Members in NF (non-Medicare paid days) (C)**	11	57	9	1,204	1,161	53	66	9	1,168	721					
# Members in HCBS **(C)- note: member can be included in more than one category listed below	19	250	64	2,305	2,191	71	257	59	2,208	1,640					
# Members in Residential Setting **(C)	5	128	9	710	1,017	6	131	14	684	838					
# Members in Self-Direction **(C)	31	42	15	887	872	6	44	13	852	901					
# Members receiving other HCBS **(C)	25	122	46	1,418	1,009	68	126	36	1,356	802					
# Members in At-Risk ** (C)						4		31	1,050	225					
# Members in Self-Direction **(C)						17		4	387	56					
# Members receiving other HCBS **(C)						1		8	352	169					
(* 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.