Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2020 1st Quarter

Hawaii QUEST Integration
Section 1115 Quarterly Report
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(via secured email)

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Table of Contents

I. Introduction 3
II. Budget Neutrality Monitoring Spreadsheet 3
III. Events Affecting Healthcare Delivery 3
A. Approval & Contracting with New Plans 3
B. Benefits & Benefit Changes 4
1115 Demonstration Renewal 4
HOPE initiative 4
Collaboration with the Department of Education (DOE) to increase Medicaid Claiming for School Based Services 4
Hawaii Administrative Rules 4
Policy and Program Directives 4
C. Enrollment and Disenrollment....... 5
Outreach/Innovative Activities 5
D. Complaints/Grievances 5
E. Quality of Care 6
F. Access that is Relevant to the Demonstration 6

G. Pertinent Legislative or Litigation Activity 7
IV. Adverse Incidents 7
A. Medicaid Certified Nursing Facilities 7
B. Long Term Services and Supports (LTSS) 8
V. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data 8
VI. Action Plans for Issues Identified In: 9
A. Policy 9
B. Administration 9
C. Budget & Expenditure Containment Initiatives 9
VII. Monthly Enrollment Reports for Demonstration Participants 10
A. Enrollment Counts 10
B. Member Month Reporting 11
C. Enrollment in Behavioral Health Programs 12
Behavioral Health Programs Administered by the Department of Health (DOH) 12
D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS) 13
LTSS Enrollment 13
VIII. Number of Participants who Chose an MCO and Number of Participants who Changed MCO After Auto-Assignment 13
Member Choice of Health Plan Exercised 13
IX. Member Grievances, and Appeals, Filed during the Quarter, by Type 14
A. Grievances 14
B. Appeals 16
X. Demonstration Evaluation and Interim Findings 19
XI. Quality Assurance and Monitoring Activity 19
Quality Activities During The Quarter July to September 2019 19
XII. Quality Strategy Impacting the Demonstration 22
XIII. Other 22
Status of Current QUEST Integration Contract 22
Provider Management System Upgrade (PMSU) 22
Electronic Visit Verification (EVV) 23
MQD Workshops and Other Events 24
A. Enclosures/Attachments 25
B. MQD Contact(s) 25

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 received two rounds of questions and in response MQD issued six Amendments to the originally issued RFP. Four MCOs submitted their proposals in response to the RFP on November 8, 2019. MQD evaluated these proposals from November 12, 2019 to January 22, 2020.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality workbook for the quarter ending September30, 2019 was submitted to CMS by the November 30, 2019 deadline. The Budget Neutrality spreadsheet for the quarter ending December 31, 2019 will be submitted separately by the February 29, 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

1115 Demonstration Renewal

MQD began monthly monitoring meetings with CMS in October to ensure compliance with the 1115 Special Terms and Conditions. In November 2019, MQD submitted its Behavioral Health Protocol to CMS. CMS is still reviewing that submission. MQD continues to be on time on all deliverables.

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. This has required intensive discussions with the HOPE leadership team and the consultants assigned to this task. The other issue we have been focusing on has been palliative care, investment in primary care, and the development of a CHIP Health Services Initiatives (HIS) SPA with technical assistance from CMS.

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. The DOE has increased efforts to comply with federal requirements to ensure Medicaid reimbursement for covered services can be fully utilized. MQD staff continues to offer guidance, assistance and information when needed. DOE staff has increased efforts statewide to be in compliance with Medicaid requirements to ensure maximum federal reimbursement for school-based Medicaid services. In October, Program and Policy Development Office (PPDO) staff attended the National Alliance for Medicaid in Education, Inc. (NAME) conference in Albuquerque, New Mexico with staff from DOE. The NAME Annual Conference is a national forum for professionals working in education and/or health care and related fields. The conference provided a unique opportunity to network with colleagues and similar professionals in the field of school-based health at the local, state and federal levels, as well as an opportunity for professional development with the latest information in research, experience and best practices for Medicaid in education.

Hawaii Administrative Rules

PPDO continues to work on amending the Hawaii Administrative Rules to be in compliance with new federal regulations and guidelines, in addition to housekeeping as needed.

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. PPDO also remains committed to ensuring programs and policies align with State initiatives such as "Ohana 'Nui" and continues to broaden collaborative efforts with other divisions, offices and other both public and private entities.

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.]

Outreach/Innovative Activities

The Health Care Outreach Branch (HCOB) conducted our Annual Statewide Kōkua Training during the month of October to recertify and train our community partners on how to properly assist clients to submit an online application to Med-QUEST, discussed and reviewed cultural competency practices, reviewed details and processes of the Federal Health Insurance Marketplace and prepared for its Open Enrollment period from November 1 – December 15, 2020. All Kōkua (Navigators), who work under our Kōkua Services contracts completed the online MLMS Federal Health Insurance Marketplace certification required to assist clients with enrollment on the Marketplace.

Our team completed another successful Open Enrollment with the Federal Marketplace and the State of Hawaii's enrollment for 2020 remained stable with a slight increase over 2019 enrollments.

We continue to do provide normal 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.

HCOB executed a Business Associate Agreement with Hawaii Homeless Healthcare Hui and are awaiting their staff to complete the required documents, HIPAA and Annual Civil Rights Requirements, so we may conduct training and provide them with Navigator access to our online KOLEA System. HCOB continues to look for ways to expand our community outreach through partnerships with non-profit organizations who serve the residents of Hawaii.

D. Complaints/Grievances

October 2019 – December 2019 Complaints/Grievances
Description: The following are complaints/grievances received by the MQD office.
4 - Follow up calls regarding open grievance
1- Provider is not getting paid from health plans
1- Member is not receiving an acknowledgment letter from the health plans
2- Denied services
1 - Resolution is incorrect/ not satisfied with resolution

2 - Health plan and physician
1 - Transportation
6 - Customer Service and Eligibility
5 - Information regarding a State Grievance
1 - Provider calls
1 - Need a new wheelchair/ not safe
2 - Falsified claims from providers and health facilities
1 - Request for specific medication
1- Payment Denial

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

E. Quality of Care

Work this quarter has been on three State Plan Amendments related to the SUPPORT Act, telehealth, and Durable Medical Equipment to ensure compliance with federal requirements. Also work on dental coverage for EPSDT was done to allow for coverage of additional codes, reimbursement adjustments for specific codes, and reviewing authorization for use of the operating room for procedures to be performed on children.

[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. Multiple meetings have continued to be held with agency providers, community advocates, managed care health plans, and other DHS staff, with the goal of designing a CIS program that will have a positive and lasting impact. Discussions have focused around recipient screening, recipient onboarding, recipient assessments, provider training, claim coding, program financing, management reporting, data analytics, and program evaluation.

During the reporting period, 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.

G. Pertinent Legislative or Litigation Activity

The legislature was not is session during this report period, however 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 12 reported adverse incident reports submitted during the period of October - December 2019.

- 9 unattended/unwitnessed fall
- 1 witnessed fall
- 2 physical injuries

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 14 reported adverse incident reports submitted during the period of October - December 2019.

- 6 ER visits due to illness
- 5 ER visits due to physical Injury (Hernia)
- 1 impacted BM
- 1 L-Ear dx Basal Cell Carcinoma
- 1 Nephrologist referral

B. Long Term Services and Supports (LTSS)

For this reporting period, October to December 2019, there were a total of 337 adverse events related to the LTSS population. The top five incident categories were: Fall, Hospital, Death, Emergency Room Visit, and Injury. Falls were the top occurring incident for the quarter. Hospitalization and Emergency Room Visit were the second most occurring incident.

Types of Adverse Events	#			
	Oct 2019	Nov 2019	Dec 2019	**TOTAL**
Fall	47	43	46	136
Hospital	25	26	20	71
Death	14	6	9	29
Emergency Room Visit	28	24	18	70
Injury	13	10	8	31
TOTAL	127	109	101	337

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 1st Quarter, MQD implemented revisions to its encounter validation protocol and began to implement a more streamlined process for addressing ongoing challenges our MCOs experience with submitting encounter data into the system. The need for a cross-cutting committee to address policy issues impacting encounter data was established, and an initial meeting of the committee was scheduled. Further, the need for additional training on coding was identified, and a class for employees across the division wishing to improve their skills with coding was contracted and scheduled. The division also finalized a contracted with its EQRO to conduct an external encounter data validation project in calendar year 2020.

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, but no corrective action was needed. The clarifications included treatment of certain assets for determination of long term care eligibility, Medicaid application requirements for special situations, and cost share/spenddown related questions.

B. Administration

During the reporting period, no administrative issues were identified for any initiatives or corrective action plans.

C. Budget & Expenditure Containment Initiatives

There were no significant financial or expenditure issues this quarter.

VII. Monthly Enrollment Reports for Demonstration Participants

A. Enrollment Counts

		Member Months	**Unduplicated Members**
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**10/2019 - 12/2019**	**10/2019 - 12/2019**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	345,699	114,479
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	102,165	33,827
Aged	Aged w/Medicare Aged w/o Medicare	84,048	28,314
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	71,184	24,030
Expansion State Adults	Expansion State Adults	276,098	91,919
Newly Eligible Adults	Newly Eligible Adults	60,999	20,253
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,581	513
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)	88,322	29,019
Total		1,030,096	342,354

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	201,163
Title XXI funded State Plan	29,019
Title XIX funded Expansion	112,172
Enrollment current as of	12/31/2019

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 12/31/19
EG 1 – Children	**116,215**	**115,911**	**115,154**	**347,280**
EG 2 – Adults	**34,215**	**34,156**	**33,794**	**102,165**
EG 3 – Aged	**27,844**	**27,936**	**28,268**	**84,048**
EG 4 – Blind/Disabled	**23,504**	**23,845**	**23,835**	**71,184**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**110,814**	**112,932**	**113,351**	**337,097**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 12/31/19
State Plan Children	**115,702**	**115,378**	**114,619**	**345,699**
State Plan Adults	**34,215**	**34,156**	**33,794**	**102,165**
Aged	**27,844**	**27,936**	**28,268**	**84,048**
Blind or Disabled	**23,504**	**23,845**	**23,835**	**71,184**

Expansion State Adults	**90,734**	**92,774**	**92,590**	**276,098**
Newly Eligible Adults	**20,080**	**20,158**	**20,761**	**60,999**
Optional State Plan Children	**0**	**0**	**0**	**0**
Foster Care Children, 19-20 years old	**513**	**533**	**535**	**1,581**
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.	**4,321**
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,	**901**

solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,138**

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 January 2020 submissions]

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

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

October 2019 – December 2019	Number of Members
Individuals who chose a health plan when they became eligible	**741**

Individuals who were auto-assigned when they became eligible	**7,406**
Individuals who changed their health plan after being auto-assigned	**2,611**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**18**

During this reporting period, 741 individuals chose their health plan since they became eligible in the previous quarter, 2,611 changed their health plan after being auto-assigned. Also, 7,406 individuals had an initial enrollment which fell within this reporting period.

In addition, 18 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 1st quarter, Health Plans and MQD received and addressed the following number of member complaints/grievances.

Member Grievances to Health Plan			
	Oct – Dec 2019	Oct – Dec 2019	Oct – Dec 2019
Submitted	**QI**	**CCS**	**TOTAL**
Total number filed during the reporting period	307	18	325
Total number that received timely acknowledgement from health plan	301	18	319
Total number not receiving timely acknowledgement from health plan	6	0	6
Total number expected to receive timely acknowledgement during next reporting period	0	0	0
Total number that received timely decision from health plan	292	16	308
Total number not receiving timely decision from health plan	10	1	11
Total number expected to receive timely decision during next reporting period	7	0	7

Total number currently unresolved during the reporting period	12	1	13
Total number overturned	0	0	0

Types of Member Grievances to Health Plans			
	Oct – Dec 2019	Oct – Dec 2019	Oct – Dec 2019
Medical	**QI**	**CCS**	**TOTAL**
Provider Policy	3	0	3
Health Plan Policy	20	0	20
Provider/Provider Staff Behavior	74	0	74
Health Plan Staff Behavior	49	0	49
Appointment Availability	4	0	4
Network Adequacy/ Availability	2	0	2
Waiting Times (office, transportation)	58	2	60
Condition of Office/ Transportation	2	0	2
Transportation Customer Service	18	1	19
Treatment Plan/Diagnosis	14	0	14
Provider Competency	27	13	40
Interpreter	0	0	0
Fraud and Abuse of Services	2	0	2
Billing/Payments	18	1	19
Health Plan Information	11	1	12
Provider Communication	17	7	24
Member Rights	3	2	5

Member Grievances to MQD				
	October 2019	November 2019	December 2019	TOTAL
Submitted	2	3	2	7
Health Plan resolved with Members	1	1	0	2
Dismiss as untimely filing	0	0	0	0
Member withdrew appeals	0	0	0	0
Resolution in Health Plan favor	0	0	0	0

Resolution in Member's favor	0	1	0	1
Still awaiting resolution	0	1	1	2
Carry-over from previous Quarter	1*	0	0	1

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

Types of Member Grievances to MQD				
	October 2019	November 2019	December 2019	TOTAL
Medical	0	0	1	1
Long Term Services and Support	0	1	0	1
Transportation	0	1	0	1
Applied Behavioral Analysis (ABA)	0	0	0	0
Durable Medical Equipment	0	0	0	0
Reimbursement	1	0	0	1
Medication	0	0	0	0
Miscellaneous	1	0	1	2

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

B. Appeals

There were a total of 355 member appeals filed with the health plan.

Member Appeals to Health Plans	
	TOTAL
Total number filed during the reporting period	355
Total number that received timely acknowledgement from health plan	318

Total number not receiving timely acknowledgement from health plan	37
Total number expected to receive timely acknowledgement during next reporting period	24
Total number that received timely decision from health plan	321
Total number not receiving timely decision from health plan	30
Total number expected to receive timely decision during next reporting period	28
Total number currently unresolved during the reporting period	28
Total number overturned	205

Types of Member Appeals to Health Plans	
	TOTAL
Service denial	78
Service denial due to not a covered benefit	54
Service denial due to not medically necessary	211
Service reduction, suspension or termination	2
Payment denial	18
Timeliness of service	0
Prior authorization timeliness	0
Other	0

There were a total of 5 appeals submitted with the Administrative Appeals Office during the quarter. There were a total of 2 appeals resolved with the health plans prior to going to hearing. There was 1 appeal which member withdrew the request. There are 2 appeals that we are still awaiting the resolution.

Member Appeals to Administrative Appeals Office (AAO)				
	Oct 2019	Nov 2019	Dec 2019	TOTAL
Submitted	1	1	3	5
Department of Human Services (DHS) resolved with health plan or Department of Health – Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing	1	1	0	2
Dismiss as untimely filing				
Member withdrew hearing request	0	0	1	1
Resolution in DHS' favor	0	0	0	0
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	1	1	2

Types of Member Appeals to Administrative Appeals Office (AAO)				
	Oct 2019	Nov 2019	Dec 2019	TOTAL
Medical	1	0	1	2
Long Term Services and Support	0	0	0	0
Van Modification	0	0	0	0
Applied Behavioral Analysis (ABA)	0	0	0	0
Durable Medical Equipment	0	0	0	0
Reimbursement	0	0	0	0
Medication	0	1	0	1
Miscellaneous – Claim Denial	0	2	0	2

X. Demonstration Evaluation and Interim Findings

During FFY 2020 1st Quarter, MQD's Health Analytics Office (HAO) began working with the team at the University of Hawaii (UH) on developing an evaluation design for the 2019-2024 1115 waiver. The UH team is a competent and enthusiastic partner to the division, and brings substantial experience in evaluation; however, the team has limited experience in working with Medicaid programs. Therefore, HAO's technical assistance has principally focused on providing technical assistance and clarification around program structure and operations. The UH team developed 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 first draft; feedback primarily focused on further guidance and clarification of the structure and program operations of MQD, and feasibility concerns and challenges related to the collection of data needed for certain types of evaluation designs. Towards the end of the FFY 2020 1st Quarter, the UH staff submitted a second draft to HAO for review. Additionally, HAO requested and received an extension of the deadline to submit the draft evaluation design to CMS, as the UH team anticipated needing additional time to finalize some aspects of the evaluation design.

XI. Quality Assurance and Monitoring Activity

Quality Activities During the Quarter July to September 2019

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)

October:
- Provided PIP technical assistance to AlohaCare and HMSA.
- Validated the Module 1 and Module 2 resubmissions and provided the tools to the health plans on 10/25/19.

November:
- Provided PIP technical assistance to Ohana.
- Completed validation of the Module 1 and Module 2 resubmissions and provided the tools to the health plans.
- Provided the Module 3 training webinar on 11/05/19.

December:

Received Module 3 submissions from AlohaCare, CCS, HMSA, Kaiser, Ohana, and UnitedHealthcare.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

October:

- HSAG sent the 2020 performance measure selection list along with HSAG's recommendations to the MQD on 10/22/19.

November:

- HSAG sent the final list of recommendations for 2020 to the MQD on 11/18/19.
- The MQD approved HSAG's recommended list of performance measures on 11/22/19.
- HSAG sent sample frame creation instructions to the MQD on 11/06/19.
- MQD generated test sample frame files (CHIP and one adult sample frame) and submit them to HSAG for review on 11/20/19.
- HSAG submitted the survey sample frame validation introductory packet to QI health plans on 11/22/19.

December:

- HSAG submitted the documentation request packets to all QI plans to initiate the HEDIS 2020 activities on 12/19/19.
- HSAG received questions from HMSA on 12/30/19, regarding the SBIRT performance measure.

3. Compliance Monitoring

October:

- Began drafting documents/tools for 2020 Compliance Reviews.

November:

- Submitted 2020 Compliance Review Document Request and Evaluation tools to the MQD for review on 11/20/19.
- Continue drafting documents/tools for 2020 Compliance Reviews.

December:

- Finalized all documents/tools for 2020 Compliance Reviews.
- Began review of health plan 2019 CAPs.

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

October:

- Received confirmation to prepare a presentation of the 2019 CAHPS results for the new EQRO nurse from the MQD on 10/24/19.

November:

- Received approval from MQD on the presentation of 2019 CAHPS results on 11/12/19.
- Received the final list of supplemental questions to include in the adult and child survey from MQD on 11/13/19 and 11/15/19, respectively.
- Notified the QI health plans of the sample frame deduplication requirements and timeframes on 11/15/19.
- Received the CHIP and AlohaCare test sample frame files from the MQD on 11/21/19.
- Received a deduplication request from AlohaCare on 11/20/19.
- Received a deduplication request from UnitedHealthcare on 11/21/19.
- Received completed administrative forms from MQD on 11/25/19.
- Received CHIP sample frame file with updated age from MQD on 11/26/19.
- Received feedback on the text for cover letters and postcard from MQD on 11/27/19.

December:

- Received final approval on the cover letters and postcard text from MQD on 12/11/19.
- Submitted CAHPS 2020 survey materials to NCQA for approval prior to volume printing and notified MQD that the first and second mail adult English letters with the nondiscrimination statement on the backsides were approved by NCQA on 12/16/19.
- Sent an updated timeline to MQD based on the subcontractor's production schedule on 12/20/19.

5. Provider Survey

October:

- No update for October

November:

- Sent the 2016 and 2018 final Provider Survey Reports to MQD for review on 11/21/19.

December:

- Received feedback on 2018 Provider Survey instruments for the 2020 Provider Survey instruments on 12/18/19.

6. Annual Technical Report

October:

- Continued compiling, analyzing, and incorporating findings, conclusions, and recommendations into the draft EQR technical report.

November:

- Finished compiling, analyzing, and incorporating findings, conclusions, and recommendations into the draft EQR technical report.
- Began peer and technical/editorial review of the report.

December:

- Submitted draft technical report to the MQD for review and comment on 12/09/19.

7. Technical Assistance

October:

- Met with DHS Health Analytics Office to discuss EQRO contract modifications on 10/03/19.
- Met with DHS Health Analytics Office to discuss quality measures on 10/03/19.
- Met with DHS Health Analytics office on 10/17/19 to discuss HILOC data and P4P measures.

November:

- Met with DHS Health Analytics Office to discuss quality measures on 11/07/19.

December:

- None at this time.

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 planned to begin earnest discussions with Myers & Stauffer on the quality strategy update in the FFY 2019 4th quarter. However, although plans were in place to begin discussion with Myers & Stauffer on the quality strategy updates, during this reporting period MQD re-focused on the new QI RFP procurement. Additional work needed to be done to ensure the timely release of the RFP, as well as, timely and accurate question and answer deliberation. Tentatively, MQD hopes to resume the quality strategy discussion during the 2nd quarter FFY 2020.

XIII. Other

Status of Current QUEST Integration Contract

During the reporting period, all MCOs signed QI Supplemental Change#12, MQD executed these contracts and submitted to CMS. Waiting for CMS's final approval after rate is approved.

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 6, 2020, to account for unforeseen complexities in business rules development and software coding and implementation.

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 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.

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 1 (Q4), 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 Good Faith Effort letter was submitted to CMS in November 2019 requesting approval for a delayed implementation of the EVV solution. The Good Faith Effort extension was approved for 2020. The EVV HCPCS service codes and modifiers memo was distributed and reviewed with the Health Plans and Provider Agencies. Currently, the revised go-live date has not been finalized as the project schedule is still being refined. The current schedule reflects a Go-Live date in late September2020.

MQD's future EVV workplans include:

The Technical Specification final approval is anticipated to occur in the first three months of 2020. 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 anticipates that the revised, and ultimately baselined, schedule will be ready in the first three months of 2020. The team will continue working with the EVV vendor towards an implementation date projected in the fall of 2020.

OCTOBER

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

NOVEMBER

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

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

MQD Workshops and Other Events

Focus:	**Going Home Plus (GHP) REBOOT" Money Follows the Person Review**		
For:	**MCO Service Coordinators**		
Speaker	Madi Silverman, MQD MFP Director	**Location**	Webinar
Length	1 hour	**Date**	October 9, 2019
Attendees	Approximately 250		
Description	Review process for identification and transition of Medicaid members from Nursing Facilities and Hospitals to Community Based LTSS • Methods for identification of eligible members and GHP Referral • Transition planning • Building rapport and working closely with discharge planners in facilities. • Maintaining long term community-based living for members; reducing emergency department utilization and readmissions to the nursing facility		

Focus:	**Home and Community-Based Services Settings Requirements: Person-Centered Dignity of Risk**		
For:	**MCO Service Coordinators**		
Speaker	Bob Sattler, Support Development Associates (SDA)	**Location**	Aloha Stadium
Length	6 hours	**Date**	November 21, 2019
Attendees	Approximately 180		
Description	Provide guidance to support dignity of risk and determine actions to better support people when delivering home and community-based services. • Risk considerations • Approaching Risk Through a Person-Centered Lens • System Factors related to Risk • Risk Mitigation tools		

Focus:	Dementia Friends		
For:	**Community Care Foster Family Homes (CCFFH) HCBS Medicaid Providers**		
Trainer	Dr. Ritabelle Fernandez	**Location**	Pearl City Library Oahu Veterans Center
Length	2 hours per session	**Dates**	November 22, 2019- 2 sessions December 18, 2019- 3 sessions December 19, 2019- 3 sessions
Attendees	Approximately 735		
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

(An up-to-date budget neutrality worksheet must be provided as a supplement to the Quarterly Report. In addition, any items identified as pertinent by the State may be attached. Documents must be submitted by title along with a brief description in the Quarterly Report of what information the document contains.)

Attachment A: QUEST Integration Dashboard for October 2019 – December 2019

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. [Data as of January 2020 submissions]

Attachment B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 9/30/2019 is attached. The Budget Neutrality worksheet for the quarter ending 12/31/2019 will be submitted by the 2/29/2020 deadline.

B. MQD Contact(s)

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808 692 8083 (phone), 808 692 8087 (fax)

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-19					Nov-19					Dec-19				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	60,299	152,191	28,855	27,234	34,507	60,315	151,617	28,844	27,232	34,916	60,140	150,997	28,792	27,068	35,121
Duals	3,466	5,436	1,238	9,823	14,884	3,488	5,489	1,242	9,764	14,900	3,546	5,538	1,258	9,781	14,962
Total	**63,772**	**157,627**	**30,093**	**37,057**	**49,391**	**63,803**	**157,106**	**30,086**	**36,996**	**49,816**	**63,686**	**156,535**	**30,050**	**36,849**	**50,083**
# Network Providers															
PCPs	771	1,002	225	791	872	784	1,016	225	798	870	800	1,023	225	801	866
PCPs - (accepting new members)	638	784	216	577	655	653	795	212	581	645	674	801	213	584	633
Specialists	2,503	2,831	467	1,544	1,567	2,503	2,814	472	1,545	1,457	2,542	2,893	475	1,545	1,459
Specialists (accepting new members)	1,701	2,831	467	990	1,419	1,702	2,814	472	990	1,302	1,741	2,893	475	990	1,309
Behavioral Health	818	1,576	118	666	1,000	815	1,589	124	666	1,046	823	1,608	124	666	1,038
Behavioral Health (accepting new members)	727	1,576	118	626	959	725	1,589	124	626	1,007	736	1,608	124	626	1,001
Hospitals	25	27	12	24	23	25	27	12	24	23	25	27	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	47	37	16	38	34	47	37	17	38	33	40	37	17	38	34
Residential Setting (CCFFH, E-ARCH, and ALF)	565	612	160	1,031	1,219	561	612	161	1,033	1,351	567	618	137	1,036	1,210
HCBS Providers (except residential settings and LTSS facilities)	75	155	68	91	77	74	156	70	91	77	72	155	70	91	73
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,837	2,322	130	1,774	1,777	1,843	2,323	132	1,776	1,603	1,857	2,361	134	1,776	1,731
Total # of providers	**6,641**	**8,562**	**1,196**	**5,959**	**6,569**	**6,652**	**8,574**	**1,213**	**5,971**	**6,460**	**6,726**	**8,722**	**1,194**	**5,977**	**6,434**
Call Center															
# Member Calls	5,261	7,609	556	8,374	4,646	3,964	5,744	848	7,001	4,201	3,939	6,143	615	6,767	3,954
Avg. time until phone answered	0:00:30	0:00:16	0:00:08	0:00:42	0:00:13	0:00:25	0:00:13	0:00:11	0:00:22	0:00:22	0:00:07	0:00:07	0:00:14	0:00:28	0:00:18
Avg. time on phone with member	0:05:09	0:07:09	0:05:10	0:07:55	0:07:07	0:06:21	0:07:19	0:04:49	0:07:36	0:07:12	0:06:07	0:06:38	0:05:40	0:08:06	0:06:57
% of member calls abandoned (member hung up)	3.6%	1.6%	0%	5.0%	0.8%	3.00%	1.9%	1%	4.9%	1.9%	0.69%	1.4%	3%	4.3%	1.4%
# Provider Calls	9,552	6,040	64	3,915	3,293	7,410	4,924	70	2,968	2,710	7,658	5,064	75	3,105	3,184
Avg. time until phone answered	0:00:31	0:00:26	0:00:11	0:01:17	0:00:04	0:00:32	0:00:19	0:00:06	0:00:27	0:00:03	0:00:19	0:00:11	0:00:23	0:00:29	0:00:04
Avg. time on phone with provider	0:05:12	0:07:45	0:03:15	0:10:35	0:07:04	0:05:54	0:08:00	0:05:20	0:11:59	0:07:26	0:06:01	0:07:32	0:05:27	0:12:14	0:06:51
% of provider calls abandoned (provider hung up)	3.7%	1.7%	0%	7.4%	0.6%	3.04%	2.1%	0%	3.1%	0.3%	1.38%	0.9%	5%	2.8%	0.4%
Medical Claims- Electronic															
# Submitted, not able to get into system	2,960	2,187	-	3,267	2,942	2,159	1699	-	2,903	3,578	2,661	7867	-	3,065	7,217
# Received	55,520	163,787	26,821	61,508	78,549	50,822	145,522	28,194	58,084	79,115	51,281	149,204	26,737	54,280	82,063
# Paid	48,605	167,387	25,923	49,428	69,645	42,409	132,257	27,014	54,340	73,671	54,931	126,978	25,158	48,262	73,541
# In Process	9,297	31,962	73	16,121	2,425	15,767	35,906	382	10,889	56,322	8,932	49,098	784	10,756	21,870
# Denied	2,684	11,988	825	7,326	7,241	2,220	9,310	798	8,450	7,179	2,831	9,034	795	6,227	8,162
Avg time for processing claim in days	5	8	1	9	7	6	9	1	8	8	6	9	1	11	7
% of electronic claims processed in 30 days	99%	99%	100%	99.6%	99.5%	98.6%	99%	99.99%	99%	99.7%	98.0%	98%	99.5%	98.4%	99.6%
% of electronic claims processed in 90 days (month to date)	99.8%	99.9%	100%	99.9%	100%	99.8%	100%	99.99%	99.9%	100%	99.9%	100%	100.0%	99.3%	99.98%
Medical Claims- Paper															
# Submitted, not able to get into system	281	956	0	215	516	276	1,074	1	161	845	313	1,238	0	176	625
# Received	19,857	17,779	57	4,744	7,187	9,771	16,017	70	4,664	6,679	13,445	15,775	21	5,733	8,273
# Paid	17,306	15,908	45	4,786	5,930	12,506	14,134	60	5,111	5,740	16,326	12,765	11	3,876	7,071
# In Process	9,344	8,506	0	2,180	436	4,914	7,976	3	860	7,141	4,129	9,067	5	1,642	3,480
# Denied	2,251	2,827	12	1,493	1,252	1,677	2,406	7	1,720	1,122	2,541	1,919	5	1,064	1,399
Avg time for processing claim in days	16	16	6	17	8	14	15	7	10	10	19	15	5	11	9
% of electronic claims processed in 30 days	95.8%	95.7%	100%	99.7%	99.8%	96.7%	95%	98.5%	98.7%	99.2%	94.4%	96%	100%	99.1%	99.2%
% of electronic claims processed in 90 days	99.5%	99.8%	100%	99.9%	100%	99.6%	100%	100%	99.4%	100%	98.7%	100%	100%	100.0%	99.9%
Prior Authorization (PA)- Electronic															
# Received	161	2,294	612	114	2,710	120	1925	534	100	2,206	128	1864	585	105	2,344
# In Process	36	382	15	108	0	22	345	19	98	0	21	279	32	97	0
# Approved	119	2,091	576	101	2,217	92	1,729	500	98	1,804	102	1,713	524	90	1,910
# Denied	25	238	18	4	268	33	233	15	6	236	17	217	29	8	249
Avg time for PA in days (month to date)	1	5	3	1	2	1	5	2	1	0	1	5	3	1	2
Prior Authorization (PA)- Paper and Telephone															
# Received	1,747	553	0	1,900	86	1,534	466	0	1,529	54	1,377	638	0	1,736	79
# In Process	327	52	0	1,790	0	326	62	0	1,440	0	209	87	0	1,604	0
# Approved	1,364	508	0	1,749	69	1,162	422	0	1,511	45	1,227	559	0	1,652	72
# Denied	207	58	0	35	8	151	34	0	29	7	152	54	0	27	4
Avg time for PA in days (month-to-date)	2	2	0	1	3	2	2	0	1	2	2	2	0	2	2
# Non-Emergency Transports															
Ground (# of round trips)	2,568	5,676	455	6922	9,389	3,078	5,373	391	6162	8,493	3,052	5,450	467	6058	8,692
Air (by segment)	1,624	1,212	262	623	915	1,361	1,724	212	542	890	1,340	1,778	242	527	763
Public Transportation Pass (bus pass & handivan coupons)	1,406	1,062	423	2146	786	1,270	1,152	490	2026	1,964	1,192	1,292	705	2046	1,152
# Member Grievances															
# Received	20	12	14	33	35	15	11	7	30	37	12	8	12	31	26
# Resolved	24	14	18	14	35	18	11	9	20	35	12	11	11	16	34
# Outstanding	11	9	9	15	9	8	9	7	10	11	8	6	8	15	3

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-19					Nov-19					Dec-19				
	AlohaCare	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**
# Provider Grievances															
# Received	82	0	0	0	0	94	1	0	1	0	112	0	0	3	0
# Resolved	7	0	0	0	0	4	1	0	0	0	27	0	0	1	0
# Outstanding	236	0	0	0	0	330	0	0	1	0	415	0	0	2	0
# Member Appeals															
# Received	5	78	2	7	17	6	66	0	7	17	9	70	0	6	12
# Resolved	5	77	0	7	9	6	68	2	9	22	6	73	0	5	14
# Outstanding	4	34	2	7	20	5	32	0	5	15	8	29	0	6	13
# Provider Appeals															
# Received	24	2	0	47	153	25	2	0	84	90	11	11	0	91	139
# Resolved	2	4	0	62	155	4	2	0	32	66	9	5	0	15	135
# Outstanding	84	18	0	15	17	101	18	0	67	41	103	24	0	143	45
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	83	88	5	128	200	74	85	4	134	170	80	79	4	127	177
Inpatient Acute Days * (A) - per 1,000	474	259	25	573	732	405	254	26	666	600	404	226	24	537	574
Readmissions within 30 days* (A)	47	178	28	46	47	41	158	35	67	37	47	137	21	63	38
ED Visits * (C) - per 1,000**	617	480	27	781	642	618	478	28	701	642	617	487	24	653	667
# Prescriptions (C) - per 1,000	9,186	10,417	658	13,544	14,661	8,523	9,674	591	12,287	13,336	8,935	9,982	635	12,842	13,525
Waitlisted Days * (A) - per 1,000	53	0	4	60	192	34	0	4	74	145	39	0	5	105	151
NF Admits * (A)	43	17	1	9	18	28	13	2	1	23	38	10	3	1	14
# Members in NF (non-Medicare paid days) (C)**	222	240	55	793	865	236	234	63	762	871	249	243	66	714	978
# Members in HCBS **(C)- note: member can be included in more than one category listed below	220	469	224	2165	1,361	250	471	225	2139	1,325	420	477	245	2096	1,495
# Members in Residential Setting **(C)	129	110	132	559	883	126	114	138	555	867	132	113	140	524	901
# Members in Self-Direction **(C)	77	181	28	834	285	80	178	32	821	272	80	182	30	806	355
# Members receiving other HCBS **(C)	93	359	196	1331	192	124	357	193	1318	185	292	366	215	1290	237
# Members in At-Risk ** (C)	455	480	109	902	980	486	503	111	892	1,003	513	529	110	883	925
# Members in Self-Direction **(C)	265	204	34	461	600	274	227	34	457	591	286	236	34	447	545
# Members receiving other HCBS **(C)	190	462	75	470	380	212	487	77	457	412	227	512	76	462	380

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

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

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

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

CMS 1500- physicians, HCBS providers eg.case management agencies, CCFFH/EARCH/ALF, home care agencies , etc.
CMS UB04- nursing facilities, FQHC, hospitals

Many health plans report utilization or frequency of services on a Per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

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

ALOHA CARE

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

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

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

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

Note: RFP requirement is 300 members for every PCP

HMSA

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

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

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

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

Note: RFP requirement is 300 members for every PCP

KAISER

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

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

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

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

Note: RFP requirement is 300 members for every PCP

OHANA

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

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

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

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

Note: RFP requirement is 300 members for every PCP

UNITED HEALTHCARE

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

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

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

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

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls as of: 12/31/2019

ALOHA CARE

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

HMSA

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

KAISER

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

OHANA

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

UNITED HEALTHCARE

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

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

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

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

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

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

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**	$ 693,404,346	$ 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**	$ 464,453,598	$ 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	501,857	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 639,049,595	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 367,016,333	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$1,070.24	
		Mem-Mon	329,548	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 836,701,711	$ 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	$3,144.25	
		Mem-Mon	316,123	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,633,609,251**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 2,790,697,896**	**$ 14,116,598,819**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 336,634,608	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,476,915,681
EG 2 - Adults	2		$ 159,521,328	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,168,804,904
EG 3 - Aged	3		$ 406,828,717	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,212,239,047
EG 4 – Blind/Disabled	4		$ 473,099,631	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,180,924,420
TOTAL			**$ 1,376,084,284**	**$ 1,647,483,577**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,458,172,469**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 693,404,346	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 336,634,608	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 356,769,738	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 267,577,304	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 464,453,598	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 159,521,328	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 304,932,270	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 228,699,202	$ 206,452,112	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 639,049,595	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 367,016,333	
		With Waiver	$ 406,828,717	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 232,220,878	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ (135,734,509)	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 174,165,659	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ -	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 836,701,711	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 473,099,631	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 363,602,080	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 272,701,560	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 943,143,725**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 771,602,662**	**$ 4,345,620,644**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 314,381,242**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 121,466,378**	**$ 1,312,805,706**
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								**$ 1,312,805,706**

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)			$ 1,690,465,526	$ 3,616,372,927	$ 5,635,289,082	$ 7,751,882,940	$ 9,770,978,175	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,809,311	$ 54,245,594	$ 56,352,891	$ 38,759,415	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (314,381,242)	$ (592,805,066)	$ (884,890,080)	$ (1,191,339,328)	$ (1,312,805,706)	
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**	$ 1,338,202,302	$ 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	1,487,933	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,338,202,302**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,920,979,175**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$768,935,299	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 768,935,299**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,459,155,226**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 1			**$ 569,267,003**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,461,823,949**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ 4,265,136	$ 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	$1,429.15	
		Mem-Mon	3,600	3,782	3,877	3,974	4,073	
TOTAL			**$ 4,265,136**	**$ 4,695,845**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 25,246,081**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ 4,253,832	$ 4,569,466	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ 4,253,832**	**$ 4,569,466**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 24,668,522**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 2			**$ 11,304**	**$ 126,379**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 577,559**

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**	$ 11,632,212	$ 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	$3,897.67	
		Mem-Mon	3,600	3,782	3,877	3,974	4,073	
TOTAL			**$ 11,632,212**	**$ 12,806,873**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 68,852,934**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ 11,601,360	$ 12,462,181	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ 11,601,360**	**$ 12,462,181**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 67,277,787**

			26	27	28	29	30	TOTAL
HYPOTHETICALS VARIANCE 3			**$ 30,852**	**$ 344,692**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,575,147**