

**Hawaii QUEST Expanded
Section 1115 Demonstration Waiver**

**Final Demonstration Evaluation Report
January 24, 2014**

Demonstration Year Ending: September 30, 2013



Table of Contents	
Executive Summary	3
Information about the Demonstration	6
Overview and Brief History of the Demonstration	6
Population Groups Impacted	7
Summary of the requirements for the evaluation in the special terms and conditions	8
Purpose, aims, objectives, and goals of the demonstration	8
Evaluation Design	11
Management and Coordination of Evaluation	11
Performance Metrics	13
Integration of the State Quality Improvement Strategy	14
Measures	16
HEDIS Measures	16
EPSDT Measures	29
CAHPS Measures	31
Physicians' Assessment Measures	39
Med-QUEST Internal Measures	41
Budget Neutrality Savings	45
Expenditures for QUEST-ACE Program	46
Recent Initiatives on Measures	47
HEDIS Initiatives	47
CMS-416 EPSDT Measures Initiatives	51
CAHPS (QUEST & QExA) Initiatives	51
Physicians' Assessment Initiatives	54
Plan All-Cause Readmission Initiatives	55
Home and Community Based Services (HCBS) Initiatives	55
Hawaii Medicaid Enrollment Initiatives	56
Recommendations	57
Conclusion	58
Appendix A	
Appendix B	

Executive Summary

The demonstration evaluation period for this report is from January 1, 2008 to September 30, 2013. This concludes the 19th demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period has seen several significant initiatives for the QUEST Expanded program:

- **Development and implementation of the QUEST Expanded Access (QExA) program on February 1, 2009.**

Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan. As of September 30, 2013, the QExA program has approximately 46,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:

- Improve the health status of the member population;
- Establish a “provider home” for members through the use of assigned primary care providers (PCPs);
- Establish contractual accountability among the State, the health plan and healthcare providers;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members;
- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member’s home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**

The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of September 30, 2013, the QUEST program has approximately 243,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans from July 1, 2008 to June 30, 2012: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans on July 1, 2012: 'Ohana Health Plan and UnitedHealthcare Community Plan.

In the new procurement effective July 1, 2012, MQD added or expanded on several new initiatives. These include:

- Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);

- Financial incentives for improving quality to their members;
- Integration of medical and behavioral health services;
- Auto-assign algorithm based upon quality instead of cost; and
- Standardization of capitation payments amongst health plans.

- **Implementation of the QUEST Adult Coverage Expansion (QUEST-ACE) program.**

In April 2007, the MQD implemented a new program called QUEST-ACE that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in HAR §17-1727-26. The QUEST-ACE benefit package encompassed the same limited package of benefits provided under the QUEST-Net program. This program continues to reducing the number of uninsured and underinsured adults in our community.

On July 1, 2012, the MQD changed the benefit package from a limited package of benefits to the same benefits as provided under the QUEST program. By changing the benefits from a limited to a full benefit package, the enrollment in the QUEST-ACE program more than doubled (from approximately 13,850 on June 30, 2012 to 28,800 on September 30, 2013).

- **Implementation of revised Quality Strategy.**

MQD implemented a new Quality Strategy in 2010 after receiving approval from CMS. As part of the implementation of the Quality Strategy, MQD has:

- Increased health plan monitoring;
- Standardized health plan reporting; and
- Implemented public reporting of health plan quality results.

- **Implementation of Pay for Performance through financial incentives in the QUEST program.**

MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. MQD utilizes improvement of both Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to measure improved quality results. For calendar years 2010 to 2012, health plans had access to a financial incentive of \$1.00 per member per month (pmpm) withhold. For calendar years 2010 to 2012, the quality measures were:

- Childhood Immunization
- Emergency Department (ED) Visits/1000
- LDL Control in Comprehensive Diabetes Care
- Chlamydia Screening
- Getting Needed Care (from CAHPS survey)

Health plans needed to either meet the Medicaid 75th percentile rate for each of the measures listed above or meet/exceed an improvement of 50% of the difference between the current rate and the rate the year before. The only exception to these measures is ED visits/1000. For this measure, health plans needed to meet or exceed the Medicaid 10th percentile.

In the QUEST procurement that was implemented on July 1, 2012, MQD increased the financial incentive withhold described above to \$2.00 pmpm and included the following measures:

- Childhood Immunization
- Chlamydia Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care:
 - HBA1C Control (<8%);
 - LDL-C Control (<100 mg/dl); and
 - Systolic and Diastolic blood pressure levels (<140/90).
- Getting Needed Care (from CAHPS survey)

Below is a chart that describes the number of quality measures of the five (5) potential measures each year that each health plan met.

	AlohaCare	HMSA	Kaiser
HEDIS/CAHPS 2010 (CY 2009)	2	2	4
HEDIS/CAHPS 2011 (CY 2010)	1	2	4
HEDIS/CAHPS 2012 (CY 2011)	1	1	5
HEDIS/CAHPS 2013 (January to June 2012)	1	2	5
HEDIS/CAHPS 2013 (July to December 2012)	0	1	5

Neither ‘Ohana Health Plan or UnitedHealthcare Community Plan was able to participate in incentives for July to December 2012 due to QUEST data only from July 1 to December 31, 2012.

The implementation of these initiatives has occurred to decrease the uninsured population in Hawaii and improve the quality of services to Hawaii’s Medicaid beneficiaries. Though results have not consistently met the benchmarks, MQD has identified several recommendations to improve future results. These recommendations include improved data gathering, collaborative partnership with health plans, and financial incentives to improve quality of services.

Information about the Demonstration

Overview and Brief History of the Demonstration

Hawaii's QUEST Expanded is a Med-QUEST Division (MQD) wide comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. The State of Hawaii implemented QUEST on August 1, 1994. The extension period for this final report is from February 1, 2008 to September 30, 2013.

QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program and offered benefits to citizens up to 300 percent FPL. Low-income women and children and adults who had been covered by the two State-only programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL. In order to be eligible for QUEST-Net, individuals must first have been enrolled in QUEST or Medicaid fee-for-service and may enroll in QUEST-Net when their income or assets rise above the QUEST or Medicaid fee-for-service eligibility limits. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals to develop a managed care delivery system for the Aged, Blind, and Disabled (ABD) population.

As a condition of the 2007 renewal the State was required to achieve compliance with the August 17, 2007, CMS State Health Official (SHO) letter that mandated by August 16, 2008, the State must meet the specific crowd-out prevention strategies for new title XXI eligibles above 250 percent of the Federal poverty level (FPL) for which the State seeks Federal Financial Participation (FFP). On March 30, 2009 the State requested that this provision be removed from the STCs. The State's request was a result of Public Law 111-3 The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), and the issuance of a Presidential memorandum to the Secretary of Health and Human services to withdraw the August 17, 2007 SHO letter. On February 6, 2009 the letter was withdrawn through SHO #09-001.

On February 18, 2010 the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment. The proposed amendment would provide a 12 month subsidy to eligible employers for approximately half of the employer's share for eligible employees newly hired between May 1, 2010 and April 30, 2011.

On July 28, 2010, the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus (HPP) program. The HPP program was recently created to encourage employment growth and employer sponsored health insurance coverage in the State.

On August 11, 2010, Hawaii submitted an amendment proposal to add the pneumonia vaccine as a covered immunization. In addition to the July 28 and August 11, 2010 proposed amendments, several technical corrections were made regarding expenditure reporting for both Title XIX and XXI Demonstration populations.

On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. On July 8, 2011, Hawaii filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. This certification grants the State a time-limited non-application of the maintenance of effort provisions in section 1902(gg) of the Act and provides the foundation for CMS to approve the State's amendment to reduce eligibility for non-pregnant, non-disabled adults with income above 133 percent of the FPL in both QUEST-Net and QUEST-ACE. On April 5, 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL.

In the July 7, 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

In June 2012, Hawaii requested to extend the QUEST demonstration under section 1115(e) of the Social Security Act. Revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates. A one year renewal was approved in December 2012. In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL with no asset limit.

Population Groups Impacted

Based on the goals and objectives of this demonstration, the targeted populations groups to be impacted are the most vulnerable and needy who do not have access to any other form of healthcare coverage. Individuals and family members who are sixty-five years old or older, or are blind, or are disabled are generally disqualified from the eligible groups. The scope of the population groups impacted by the demonstration has consistently and regularly been expanding from its initial focus. In its current form, the following populations are expected to benefit from this demonstration:

- Pregnant women in families whose income is up to 185 percent of the FPL;

- Infants and children in families whose income is up to 300 percent of the FPL;
- Adults and families with dependent children whose income is up to 100 percent of the FPL;
- Childless adults whose income is up to 100 percent of the FPL; and
- Uninsured individuals in general.

Summary of the requirements for the evaluation in the special terms and conditions

The State must provide an update on evaluation status monthly to the Centers for Medicare & Medicaid Services (CMS) during State/CMS calls.

The State must submit a draft evaluation design at the start of the waiver. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period when submitting a request for Demonstration extension. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

Purpose, aims, objectives, and goals of the demonstration

Goals and Objectives of the Demonstration

The goals and objectives of the demonstration include:

- Developing a managed care delivery system for the Aged, Blind, and Disabled (ABD) population that would assure access to high quality, cost-effective care;
- Coordinating care for the ABD population across the care continuum (from primary care through long-term care);
- Increasing access to a health care benefit for low-income children;
- Developing a program design that is fiscally sustainable over time; and
- Developing a program that places emphasis on the efficacy of services and performance.

Hypotheses on the Outcomes of the Demonstration

The state's hypotheses about the outcomes of the demonstration are based on State Quality Improvement Strategy targets. The following outcomes are expected in this demonstration:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.
- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.
- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.
- Comprehensive Diabetes Care (CDC):
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.
 - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the HEDIS 75th percentile.
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the HEDIS 75th percentile.
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the HEDIS 75th percentile.
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<130/80) to meet/exceed the 2010 HEDIS 75th percentile.
 - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.
- Cholesterol Management in Patients with Cardiovascular Conditions (CMC): Increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the HEDIS 75th percentile.
- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.
- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.
- Emergency Department Visits (AMB): Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 10th percentile.
- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure ‘Rating of Health Plan’ measure to meet/exceed CAHPS Adult Medicaid 75th percentile.
- How well doctors communicate: Increase performance on the state aggregate CAHPS measure ‘How well doctors communicate’ measure to meet/exceed CAHPS Adult Medicaid 75th percentile.
- Home and Community Based Service (HCBS) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.

Key Interventions Planned

The key interventions planned in for the evaluation of the demonstration include:

- Monitoring of annual Healthcare Effectiveness Data and Information Set (HEDIS) measures gathered from health plans from both the QUEST and QExA programs;
- Monitoring of utilization of home and community based services in the long term supports and services population;
- Monitoring of enrollment numbers monthly;
- Conducting CAHPS surveys annually; and
- Conducting provider surveys biennially.

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

The evaluation was conducted internally within Med-QUEST Division (MQD), primarily by the Health Care Services Branch (HCSB). The MQD works in concert with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), on collection of information from the health plans. This includes validation of several HEDIS measures, performing annual CAHPS survey and biennial provider surveys.

The HCSB receives the raw data from HSAG and analyzes it against demonstration goals. The MQD team that conducts the evaluation includes:

- Jon Fujii, Research Officer- primary lead
- Dr. Curtis Toma, MQD Medical Director
- Madi Silverman, Home & Family Access Program Manager
- Cori Woo, Contract and Compliance Section Administrator
- Patricia M. Bazin, Health Care Services Branch Administrator
- Brian Pang, Finance Officer

Timeline for Implementation of the Evaluation and for Deliverables

Summary of Timeline for Annual Quality Activities

Time Frame	Activity
February/March	Mail CAHPS surveys to Medicaid beneficiaries
March/April	Health plan site visit by MQD and EQRO to gather HEDIS data from previous year
April	Preliminary HEDIS results due to EQRO
May	Close CAHPS surveys to Medicaid beneficiaries
July	Final HEDIS results released by EQRO to MQD
July	EQRO releases CAHPS star report to MQD
September	EQRO releases CAHPS final report to MQD
October	Analysis of health plan HEDIS results to NCQA quality compass (i.e., compare to 75 th and 90 th results for Medicaid populations)
November	EQRO releases annual final report to MQD
November	Develop consumer guides for QUEST and QExA health plans Note: the consumer guide is a summary of several HEDIS measures and CAHPS survey results for health plans in both the QUEST and QExA programs that is provided to the public
December	Release of the following items for public reporting: <ul style="list-style-type: none">• EQRO annual report• QUEST Consumer Guide• QExA Consumer Guide

Summary of Timeline for Biennial Quality Activities

Time Frame	Activity
April	Mail survey to Medicaid health plan providers
June	Close survey to Medicaid health plan providers
October	EQRO releases final provider survey results to MQD

Summary of Timeline for Annual Deliverables

Time Frame	Activity
February	Submit quarterly report for September to December
March	Submit annual report for State Fiscal Year (July to June) of previous year
May	Submit quarterly report for January to March
August	Submit quarterly report for April to June
November	Submit quarterly report for July to September

Summary of Timeline for Compilation of Final Demonstration Evaluation Report

July to November	Analyze data from previous demonstration years
December	Compile information into report
January	Submit report to CMS

Performance Metrics

Summary of Performance Metrics

When observing the various measures below, and unless stated otherwise, remember that a higher numeric score is considered positive and a lower numeric score is considered negative.

Measures	Reported Years	Latest Score	Target Score
HEDIS Measures:			
Use of Appropriate Medications for People With Asthma, Total (ASM)	HEDIS 2008-2013	81.3%	87.6%
Eye Exam (CDC)	HEDIS 2008-2013	59.1%	62.5%
HbA1c Testing (CDC)	HEDIS 2008-2013	82.7%	87.3%
HbA1c Control <7.0% (CDC)	HEDIS 2008-2013	26.0%	39.9%
Poor HbA1c Control >9% (CDC) #	HEDIS 2008-2013	48.0%	35.8%
LDL-C Screening (CDC)	HEDIS 2008-2013	77.5%	80.5%
LDL-C Level <100 mg/dL (CDC)	HEDIS 2008-2013	36.8%	40.1%
Medical Attention for Nephropathy (CDC)	HEDIS 2009-2013	79.6%	82.7%
Blood Pressure Controlled <140/80 mm Hg (CDC) *	HEDIS 2008-2013	38.9%	44.5%
LDL-C Screening (CMC)	HEDIS 2009-2013	82.5%	85.3%
LDL-C level <100 mg/dL (CMC)	HEDIS 2009-2013	43.2%	57.5%
Controlling High Blood Pressure (CBP)	HEDIS 2009-2013	51.6%	63.0%
Child Immunizations Status, Combination 2 (CIS)	HEDIS 2008-2013	70.6%	81.7%
Breast Cancer Screening (BCS)	HEDIS 2008-2013	51.5%	57.7%
Cervical Cancer Testing (CCS)	HEDIS 2008-2013	67.2%	72.0%
Chlamydia Screening (CHL)	HEDIS 2008-2013	63.7%	63.7%
Emergency Department Visits, per 1,000 member months, Total (AMB) @	HEDIS 2008-2013	40.6	44.7
EPSDT Measures:			
Screening Ratio	FFYE 2007-2012	0.99	0.82
Participant Ratio	FFYE 2007-2012	0.77	0.59
CAHPS Measures:			
Rating of Health Plan	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.56 QExA: 2.26	2.62
Rating of Personal Doctor	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.66 QExA: 2.63	2.65
Rating of Specialist Seen Most Often	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.47 QExA: 2.66	2.62
How Well Doctors Communicate	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.68 QExA: 2.66	2.72
Getting Needed Care	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.31 QExA: 2.33	2.45
Getting Care Quickly	QUEST: 2008-2013 QExA: 2010-2013	QUEST: 2.51 QExA: 2.51	2.66
Physicians' Assessment Measures			
Attitude toward Hawaii Med-QUEST	2009, 2011	34.7%	N/A
Satisfaction with reimbursement from the Med-QUEST health plan	2009, 2011, 2013	29.9%	N/A
Does the health plan personnel have the necessary professional knowledge	2009, 2011, 2013	20.7%	N/A
Impact of the health plan's UM (prior authorizations) on quality care	2009, 2011, 2013	16.5%	N/A
Med-QUEST Internal Measures			
HCBS % of Nursing Home Population	2008 - 2013	67.1%	N/A
Cumulative Savings from Increase in HCBS Population	2008 - 2013	\$165,890,000	N/A
Medicaid Enrollment	2008 - 2013	292,423	N/A
Budget Neutrality Savings	DY 20	\$266,917,523	> 0

(#) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 25th %ile, NOT the score for the 75th %ile.

(@) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 10th %ile, NOT the score for the 75th %ile.

(*) This numerator changed from BP <130/80 to BP < 140/80 in HEDIS 2011.

Population Groups of Enrollees for which Data will be Analyzed

- Individuals with a diagnosis of Asthma.
- Individuals with a diagnosis of Diabetes Mellitus.
- Individuals with a diagnosis of Cardiovascular disease.
- Children up to 21 years old.
- Women ages 21 years and older.

Methods by which the data collected will be analyzed, including the statistical methodologies to be used

The results of the data collection and calculation will be various values for the given period. These results will be displayed in graphical format. For most measures, a longitudinal comparison will be made among the various years' Hawaii statewide QUEST scores. Where applicable, comparison to State Quality Improvement Strategy targets will also be reviewed.

A determination will be made if unexpected or expected factors are influencing the calculated values. These factors could be internal to DHS, specific to a plan's operations, or external at a state or national level. Either way, there will be a discussion on how we believe these factors are exerting influence on the values.

Initiatives related to each measure will be discussed. These may be conducted by the health plan or by the MQD, and in each case was implemented to improve the quality of care or collection of data related to the measure calculation.

Integration of the State Quality Improvement Strategy

The MQD started working with CMS, with Gary Jackson as the contact, in January 2010 on the revision of the Quality Strategy. MQD followed the CMS toolkit and checklist for State Quality Strategies as well as the Delaware Quality Strategy as a template. In May 2010, MQD submitted the revised Quality Strategy to CMS. The public comment period ended on September 9, 2010 and MQD received approval of its Quality Strategy. A copy of the current Quality Strategy is posted at the MQD website (www.med-quest.us). MQD is in the process of updating its Quality Strategy.

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. HEDIS measures that the health plans report

to us are reviewed and updated each year. As MQD evaluates the demonstration, the Quality Strategy is used as the framework for the evaluation.

The Health Services Advisory Group (HSAG) is the MQD's External Quality Review Organization (EQRO). Many of the MQD's quality activities are completed in partnership with HSAG. HSAG compiles and validates both QUEST and QExA HEDIS measures annually. In addition, HSAG administers both the CAHPS and provider surveys for MQD.

HSAG provides this data to us in the timeframe established in the *Timeline for Implementation of the Evaluation and for Deliverables* section. MQD analyzes this data as part of the annual parts of the evaluation of the demonstration.

Finally, HSAG submits an annual report to MQD in December of each year. MQD posts this report on our website ([www. med-quest.us](http://www.med-quest.us)) under the Managed Care/Consumer Guides section for public awareness.

Steps were taken to ensure that measures in the State Quality Improvement Strategy were reported here. These measures included comparisons to the targets from the State Quality Improvement Strategy. There are also measures that are not a part of the State Quality Improvement Strategy in this report.

Measures

The graphs used to illustrate the various measures are, unless otherwise noted, scaled from 0% to 100%. This was done to facilitate comparisons between graphs and to present a consistent scale of measurement.

Initiatives related to these measures are reported separately in a subsequent section of this report.

HEDIS Measures

The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST and QExA plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan, and UnitedHealthcare Community Plan. It should be noted that prior to HEDIS 2011, only the QUEST recipients are reflected in the HEDIS scores. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning in January 1 and ending on December 31 of the report year, and are due to Med-QUEST on approximately June 30 of the following year. These are sent via standard NCQA electronic file (IDSS) to Med-QUEST, and are then weight-averaged to create composite HEDIS measures for the entire Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by our External Quality Review Organization (EQRO).

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures. The measures presented below are a small sample of the complete set of HEDIS measures that are reported each year,

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from 2008 to 2013. A comparison is made to the 2013 National Medicaid Median 75th Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75th Percentile score as the target score for most of the HEDIS measures.

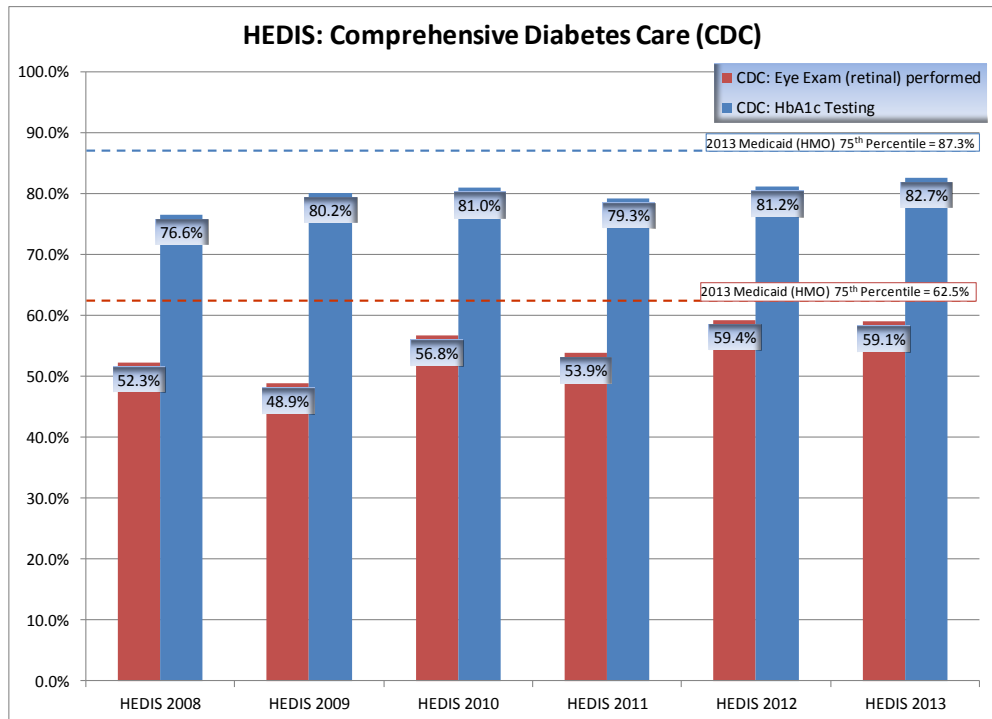
For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits, higher numeric scores are considered positive and lower numeric scores are considered negative; for these measures lower numeric scores are considered positive and higher numeric scores are considered negative.

ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2013, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have substantially increased the rates in 2012 or 2013.
- The 2013 year's score have started to increase from the low value in 2012. The raise is moving the HEDIS values more consistently towards the previous four-year range between 85% and 88%.
- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 87.6% that is consistent with the previous years reported.

CDC – Eye Exam:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed varied between 48% and 60% from 2008 to 2013, with the highest



rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

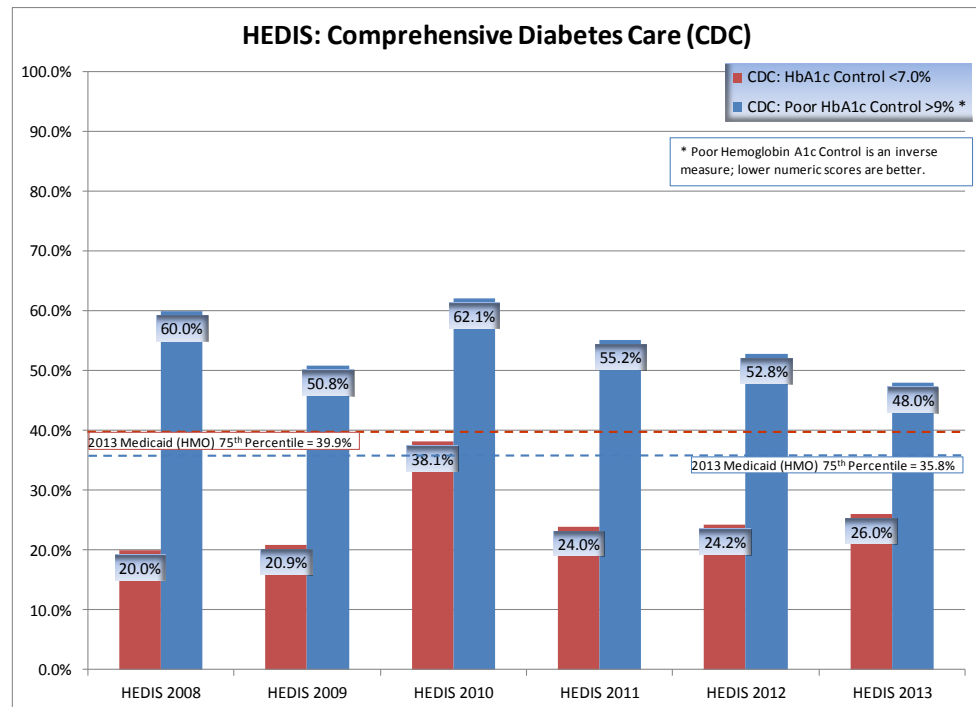
- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported a rate consistent with 2012. The first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 62.5%.

CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 83% from 2008 to 2013, with the highest rate of 82.7% occurring in 2013 and the lowest rate of 76.6% occurring in 2008.
- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 87.3% that is above all of the years reported.

CDC – HbA1c Control <7.0%:

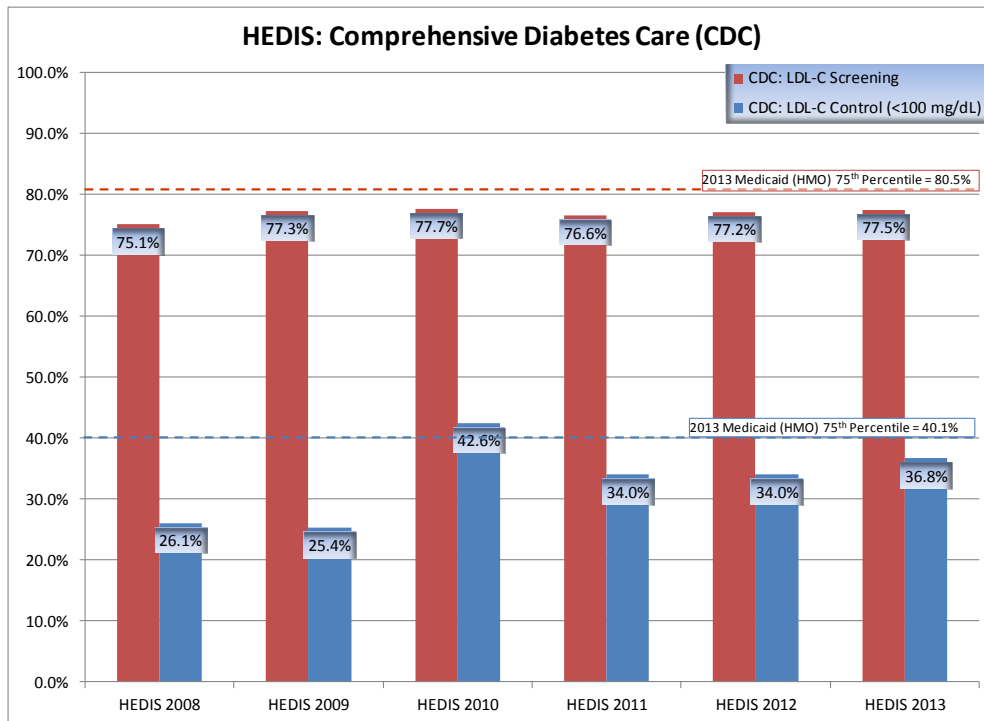
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under good control varied between 20% and 39% from 2008 to 2013, with the highest rate of 38.1% occurring in 2010 and the lowest rate of 20.0% occurring in 2008.



- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported the highest rate (except for the outlier of 38.1% in 2010), and the earliest year (2008) reported the lowest rate. In 2010, the rate of 38.1% seems like an outlier score especially when considering the five other years' scores were between 20.0% and 26%
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 39.9% that is above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 48% from 2008 to 2013, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 48.0% occurring in 2013. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a slight downtrend (good) to flat trend in the rates of the six years reported. The last four years' score went from 62.1% to 55.2% to 52.8% to 48.0%, with the lowest score occurring in 2013 (48.0%).
- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25th percentile of the national Medicaid population. For the 2013 this target was 35.8%, which is below (not good) all of the years reported.



CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 78% from 2008 to 2013, with the highest rate of 77.7% occurring

in 2010 and the lowest rate of 75.1% occurring in 2008.

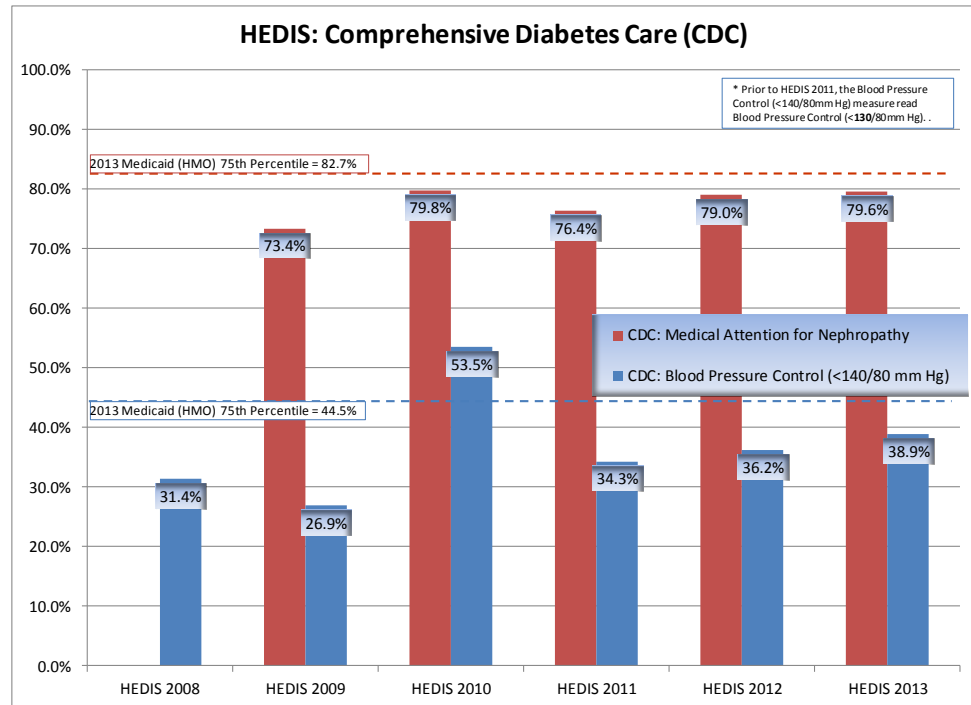
- There is a flat trend (no trend) in the rates of the six years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 80.5% that is higher than all of the years reported.

CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2013, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.
- There is a flat trend (no trend) in the rates of the six years reported. The last three years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with a national averages -- this target was 40.1% that is higher than all of the years reported (except for 2010 (42.6%)).

CDC – Medical Attention for Nephropathy:

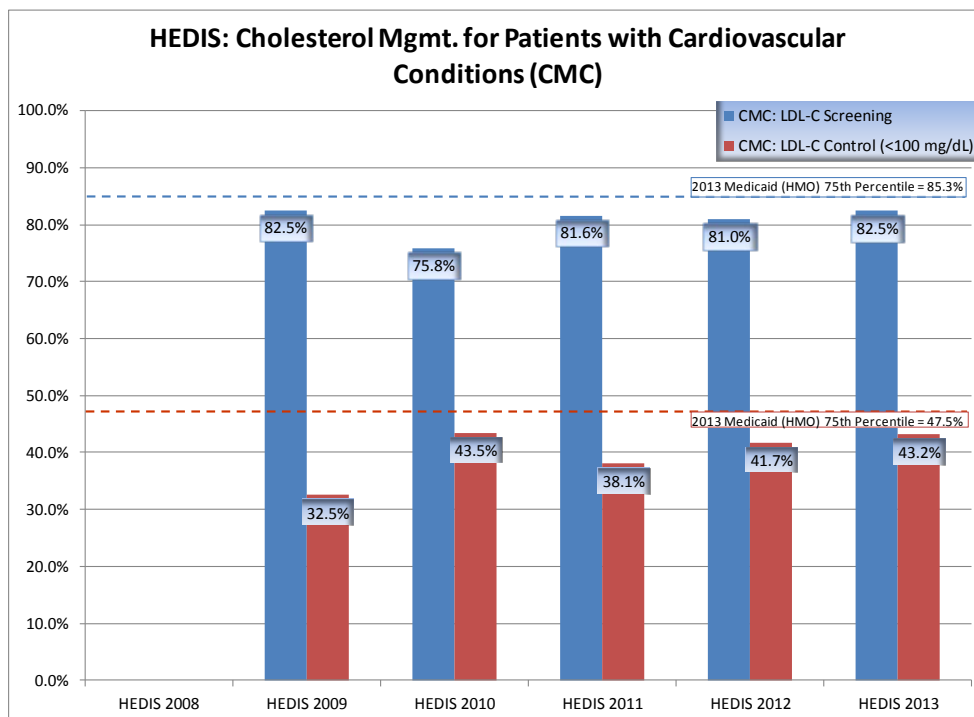
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 80% from 2009 to 2013, with the highest rate of 79.8% occurring in 2010 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.



- There is a slight up trend in the rates of the five years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2013) had a rate (79.6%) not much lower than the 79.8% in 2010.
- The HI Quality Strategy target percentage for the Medical Attention for Nephropathy measure is the 75th percentile of the national Medicaid population. For the 2013 this target was 82.7% that is higher than all of the years reported.

CDC – Blood Pressure Control (<140/80 mm Hg):

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2013, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.
- There is a slight up trend in the rates of the six years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2012 (36.2%) and 2013 (38.9%).
- The HI Quality Strategy target percentage for the CDC Blood Pressure Control (<140/80 mm Hg) measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 44.5% that is higher than all of the years reported except for in 2010.



CMC – LDL-C Screening:

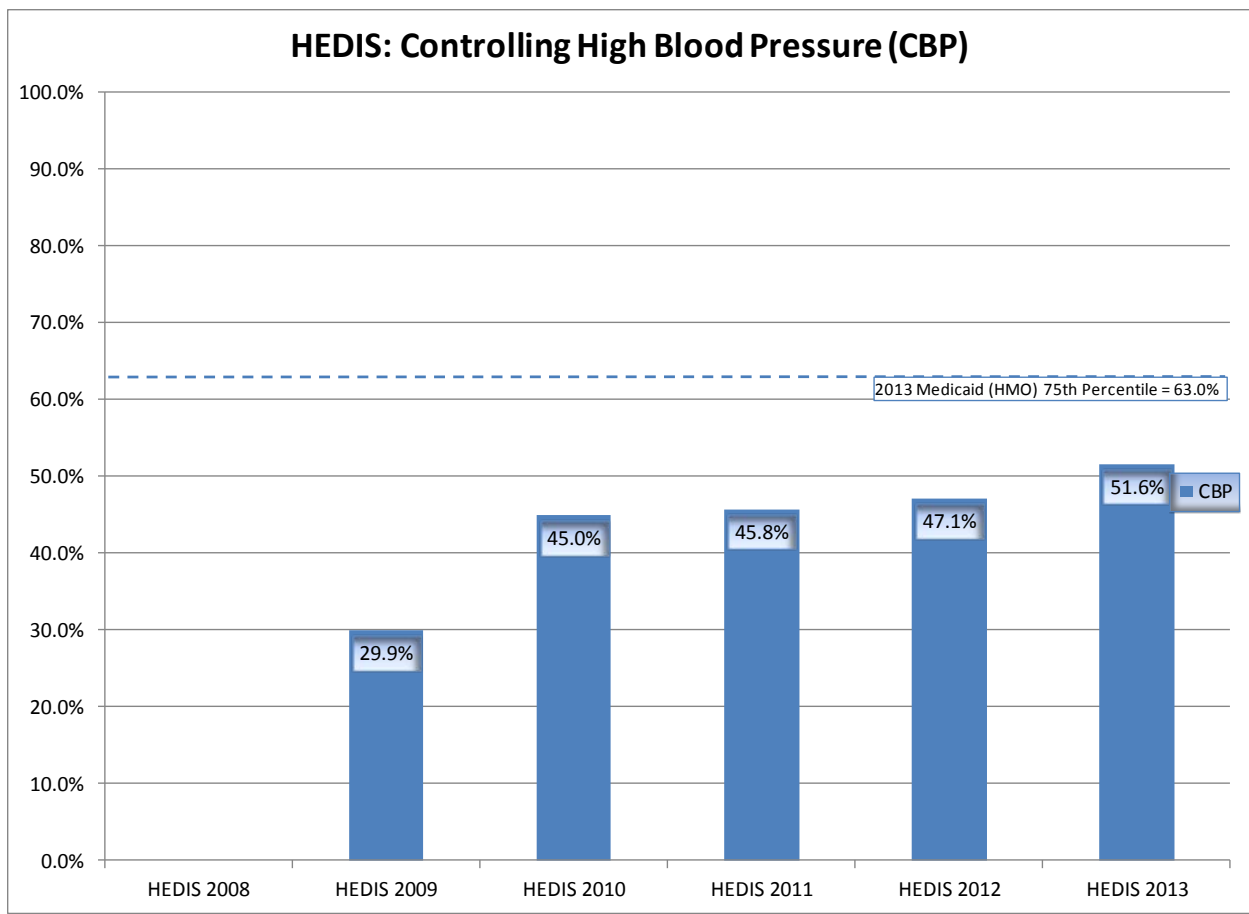
- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 83% from 2009 to 2013, with the highest rate of 82.5% occurring in 2009 (and 2013)

and the lowest rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first and last year (2009 and 2013), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 85.3% that is higher than all of the years reported.

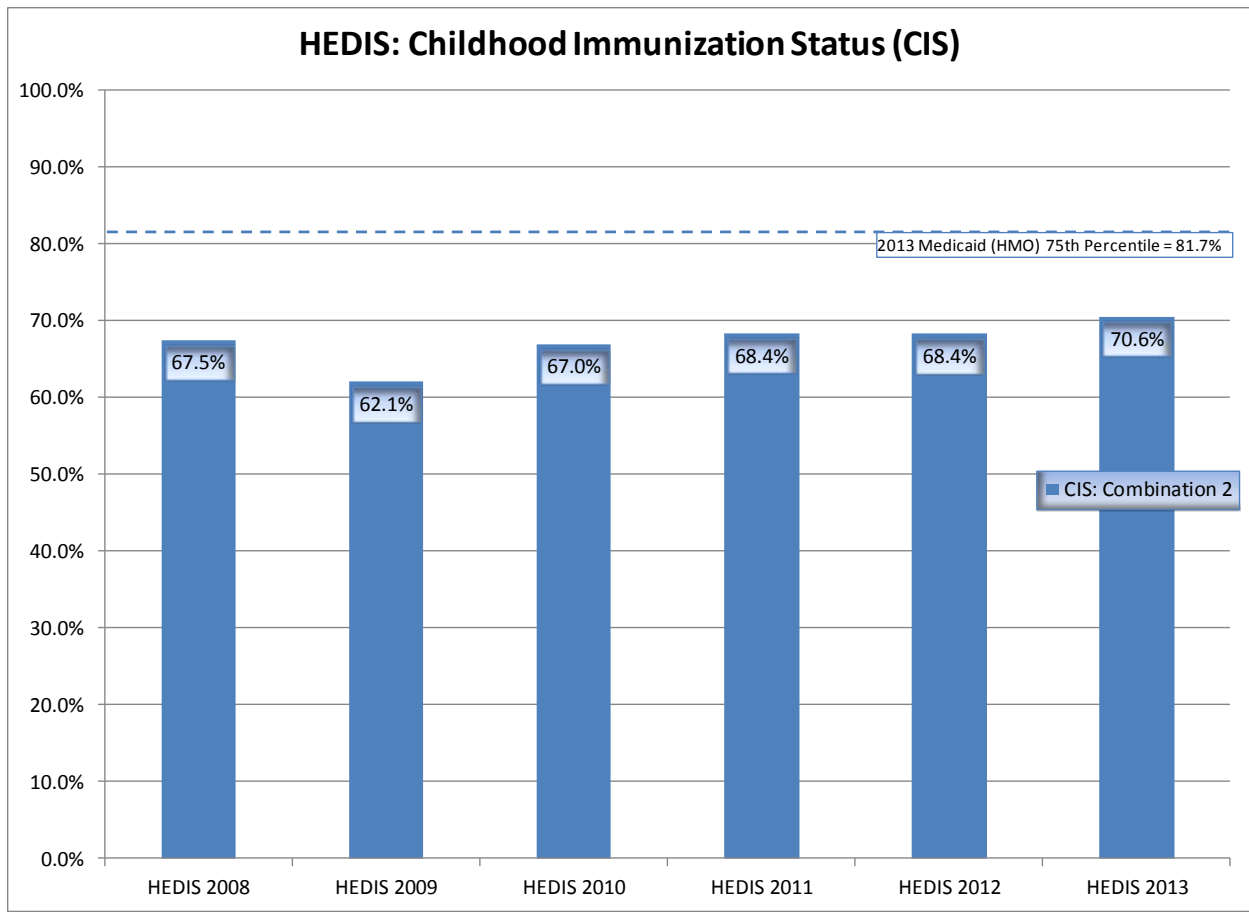
CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 44% from 2009 to 2013, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.
- There is a slight up trend in the rates of the six years reported. The rate in 2013 (43.2%) is approaching the higher rate is 2010 (43.5%).
- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 47.5%.



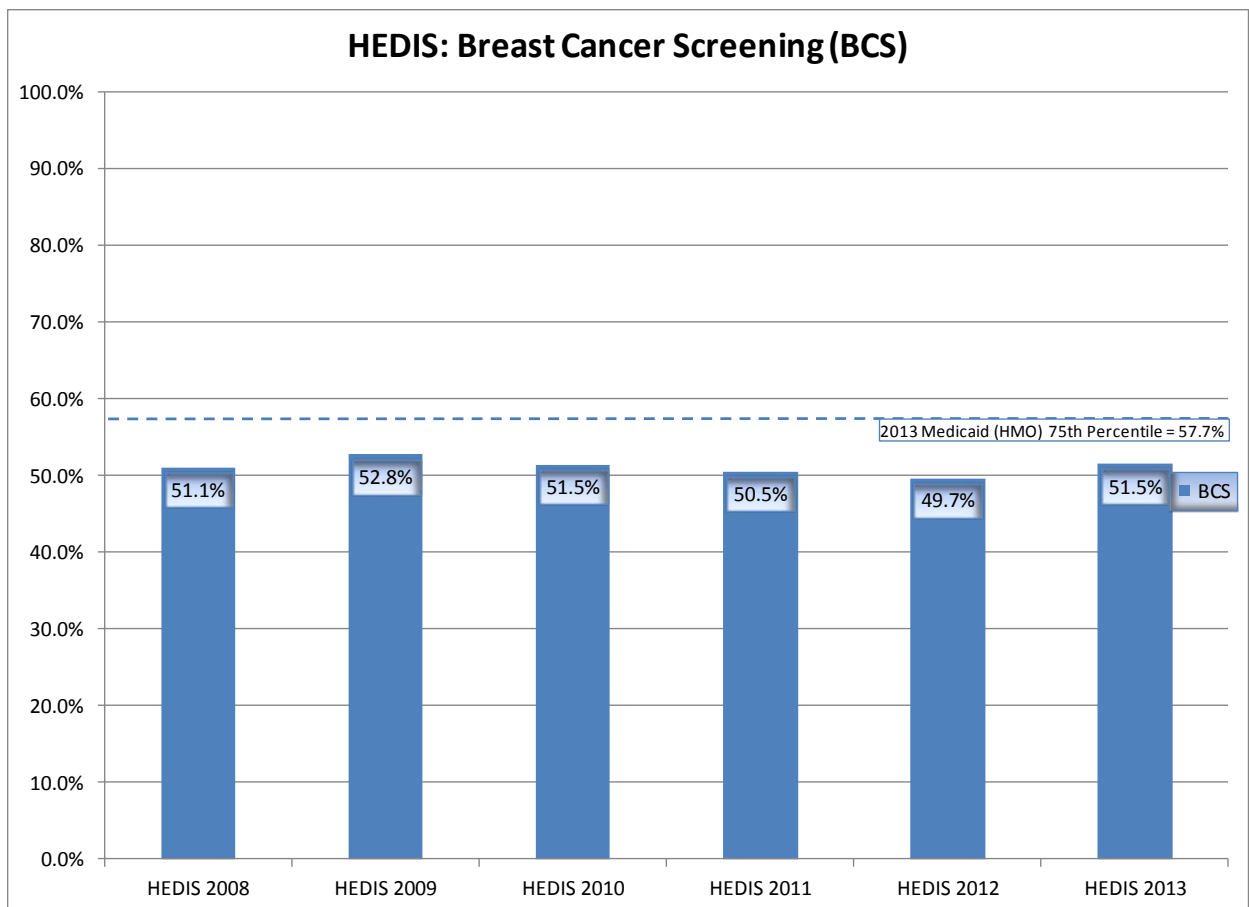
CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 52% from 2009 to 2013, with the highest rate of 51.6% occurring in 2013 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.
- There is a clear up trend in the rates of the six years reported. From 2009 thru 2013, each subsequent year's score is higher than the last.
- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 63.0% that is higher than all of the years reported.



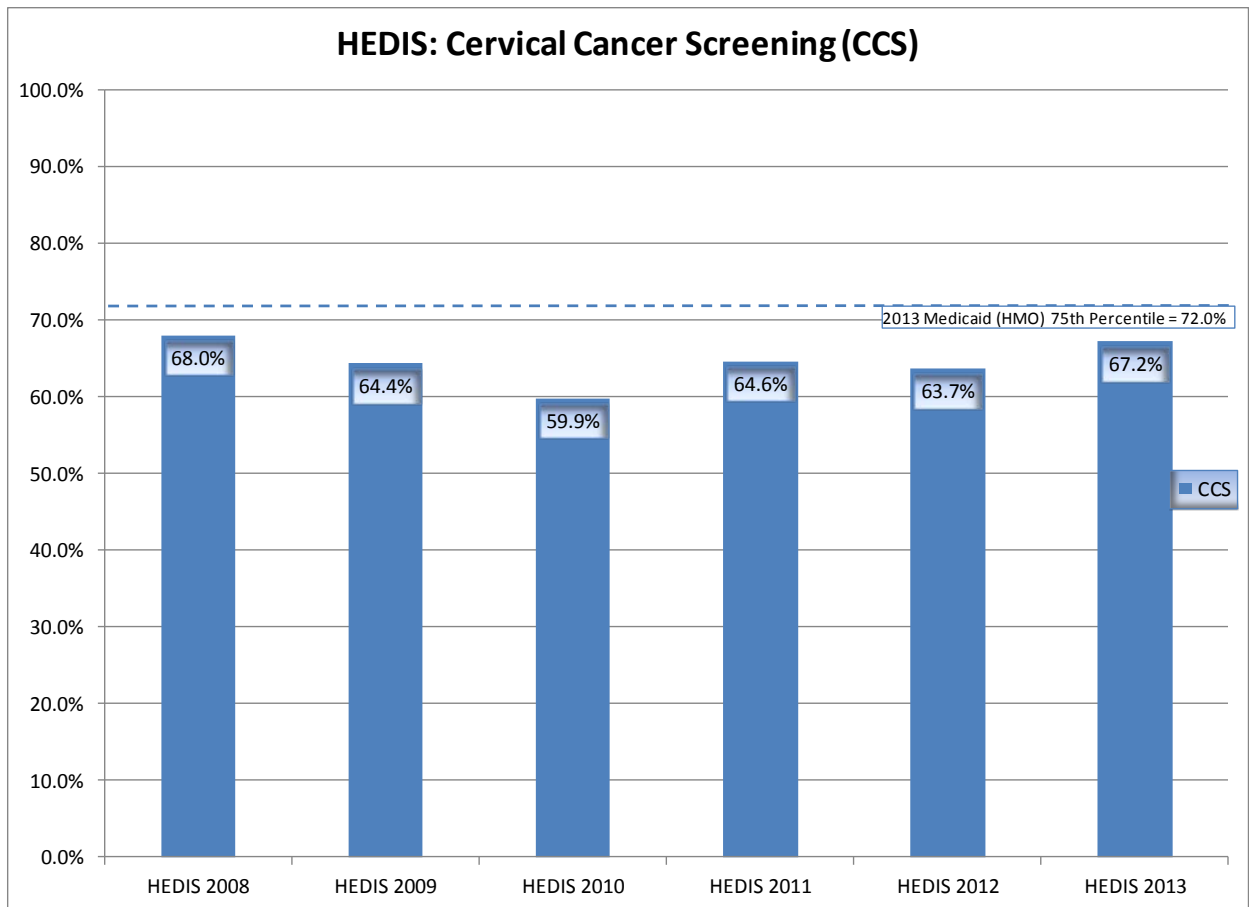
CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 71% from 2008 to 2013, with the highest rate of 70.6% occurring in 2013 and the lowest rate of 62.1% occurring in 2009.
- There is a slight up trend in the rates of the six years reported. Excluding the 2008 rate, the rates increased from 2009 to 2013 by 3.1 percentage points with no annual decreases.
- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 81.7% that is higher than all of the years reported.



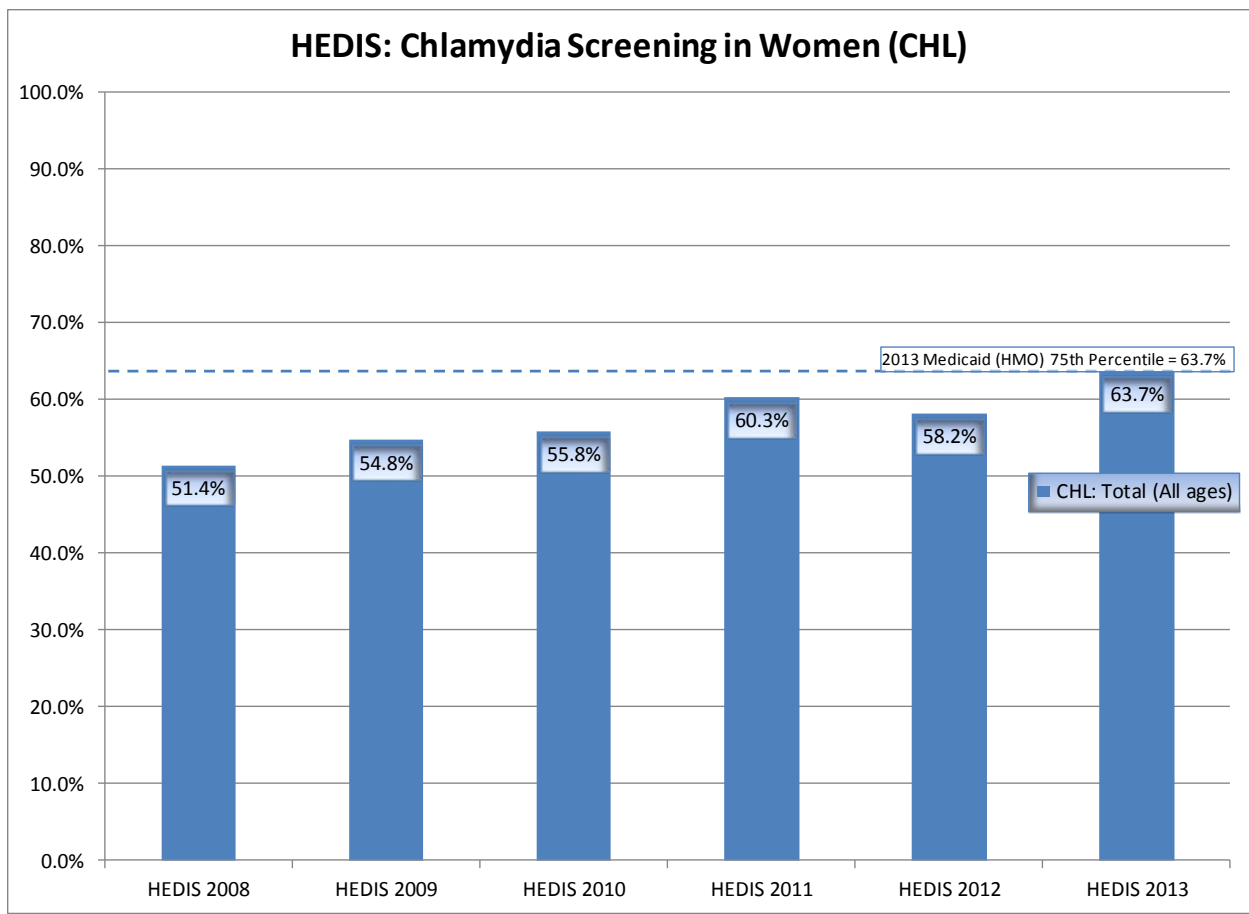
BCS:

- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 53% from 2008 to 2013, with the highest rate of 52.8% occurring in 2009 and the lowest rate of 49.7% occurring in 2012.
- There is a clear down trend in the rates for the first five years reported; the last year (2013 with 51.5%) shows strong improvement.
- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 57.7% that is higher than all of the years reported.



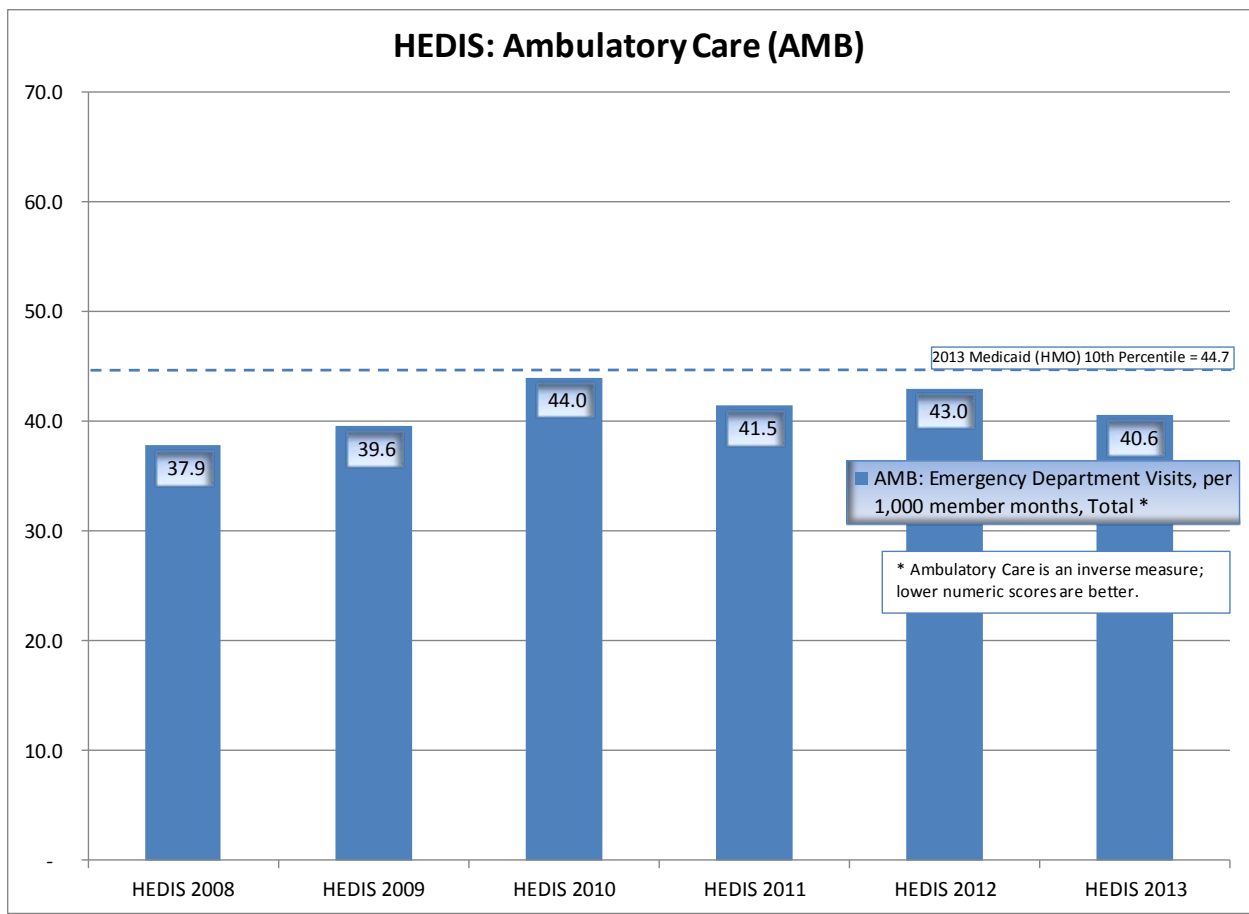
CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2013, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.
- There was a slight down trend in the rates of the first five years reported; the rate in 2013 (67.2%) increased to the previous trend in 2008 (68.0%).
- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 72.0% that is higher than all of the years reported.



CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 64% from 2008 to 2013, with the highest rate of 63.7% occurring in 2013 and the lowest rate of 51.4% occurring in 2008.
- There is a clear up trend in the rates of the six years reported. The lowest rate (51.4%) is in 2008 and the highest rate (63.7%) is in 2013.
- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 63.7%. In 2013, HI met its quality strategy target.



AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2013, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a clear up trend in the rates of the six years reported. The rate in 2013 (40.6%) is starting to trend downward again.
- The HI Quality Strategy target percentage for the CCS measure is the 10th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 44.7, which is higher (good) than all of the years reported. HI met its quality strategy goal for ambulatory care.

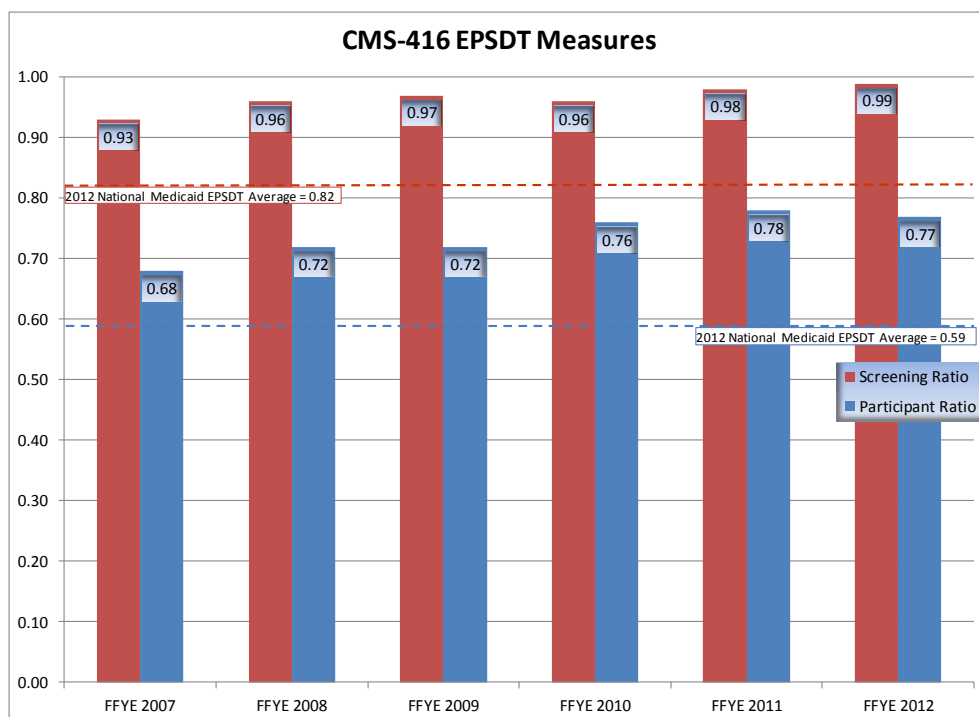
EPSDT Measures

The EPSDT measures are included in this report to measure the degree of comprehensive and preventive child healthcare for individuals under the age of 21.

The EPSDT measures are based on self-reported EPSDT reports received from the five individual plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan and UnitedHealthcare Community Plan. The scores from these individual plan reports are then weight-averaged to calculate Hawaii composite scores. All five plans create custom queries to calculate their scores, and all of the EPSDT measures are reported in each year. The format and method of calculation for the various EPSDT measures reported by the plans is no different from the national standard CMS-416 EPSDT format, aside from small differences in the periodicity of visits by state. Audits on how the plans calculate and report their EPSDT scores are not currently conducted; future health plan audits on the EPSDT calculation and reporting are being considered. EPSDT reports from the plans are based on the federal fiscal year, a twelve month period beginning in October 1 and ending on September 30 of the report year, and are due to Med-QUEST on the last day of February in the year following the report year. The measures presented below are a small sample of the complete set of EPSDT measures that are reported each year.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Scores are reported for each year from 2007 to 2012. A comparison is made to the National Medicaid EPSDT Average score – the 50th percentile – to bring perspective to where we stand on a national level.

For all of the EPSDT measures, higher numeric scores are considered positive and lower numeric scores are considered negative.



EPSDT – Screening Ratio:

- The statewide Medicaid screening ratio from the EPSDT report varied between 0.93 and 0.99 from 2007 to 2012, with the highest rate of 0.99 occurring in 2012 and the lowest rate of 0.93 occurring in 2007.

- There is a clear up trend in

the rates of the six years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.99 was reported in the last year (2012), with a mostly steady uptrend in between.

- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2012 – the latest reported year – then national average is 0.82, which is lower than all of the years reported.

EPSDT – Participant Ratio:

- The statewide Medicaid participant ratio from the EPSDT report varied between a high of 0.78 occurring in 2011 and the lowest rate of 0.68 occurring in 2007.
- There is a clear up trend in the rates of the six years reported. Each year’s score was at least equal to, and more often greater than, the previous year’s score, ending in a high of 0.78 in 2011.
- The MQD quality strategy has no benchmark for the EPSDT Participant Ratio. For comparison purposes in 2012 – the latest reported year – then national average is 0.59, which is lower than all of the years reported.

CAHPS Measures

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

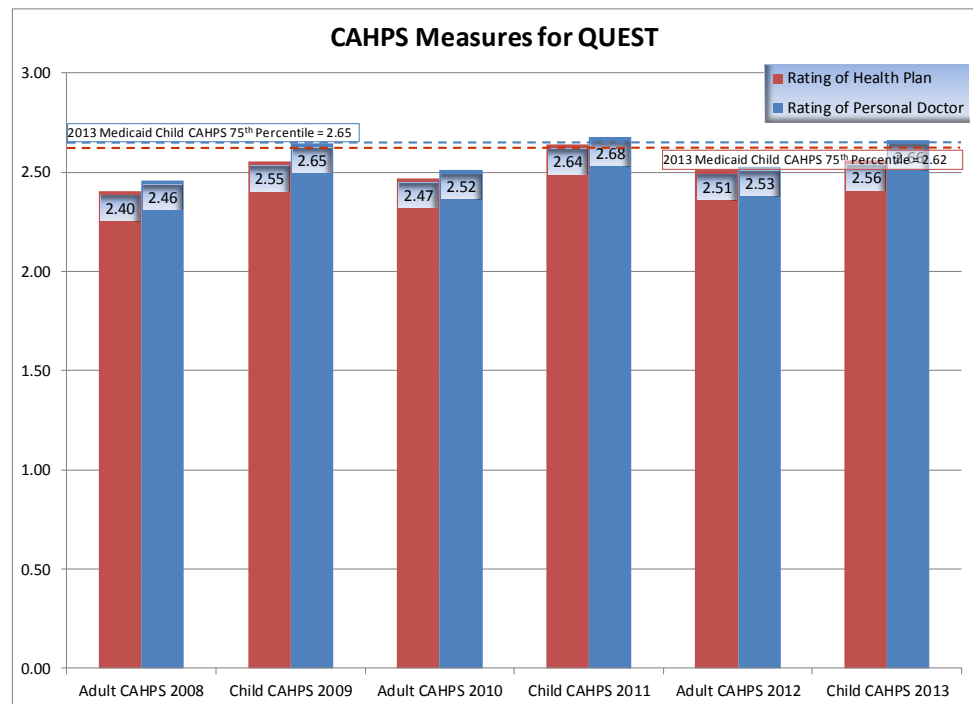
Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 45% in 2011, 38% in both 2012 and 2013. The “question summary rates” are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010, and 2012, and the Child Medicaid survey was done in 2009, 2011, and 2013. All six years results are reported here. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan as well as program (QUEST vs. QExA). Since the QExA program was begun in February 2009, there are a limited number of years of CAHPS data for QExA. This report presents the rates of the QUEST population and the QExA population in separate charts. Going forward and as required by the State of Hawaii, these surveys will continue to be done annually, with the Child and Adult surveys being done in alternating years. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows. A comparison is made to the National Medicaid Child CAHPS 2013 75th percentile score to bring perspective to where we score on a national level. The National Medicaid 75th percentile score will be the target score for all of the CAHPS measures, as is specified in our Quality Strategy.

For the CAHPS measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

CAHPS for QUEST – Rating of Health Plan:

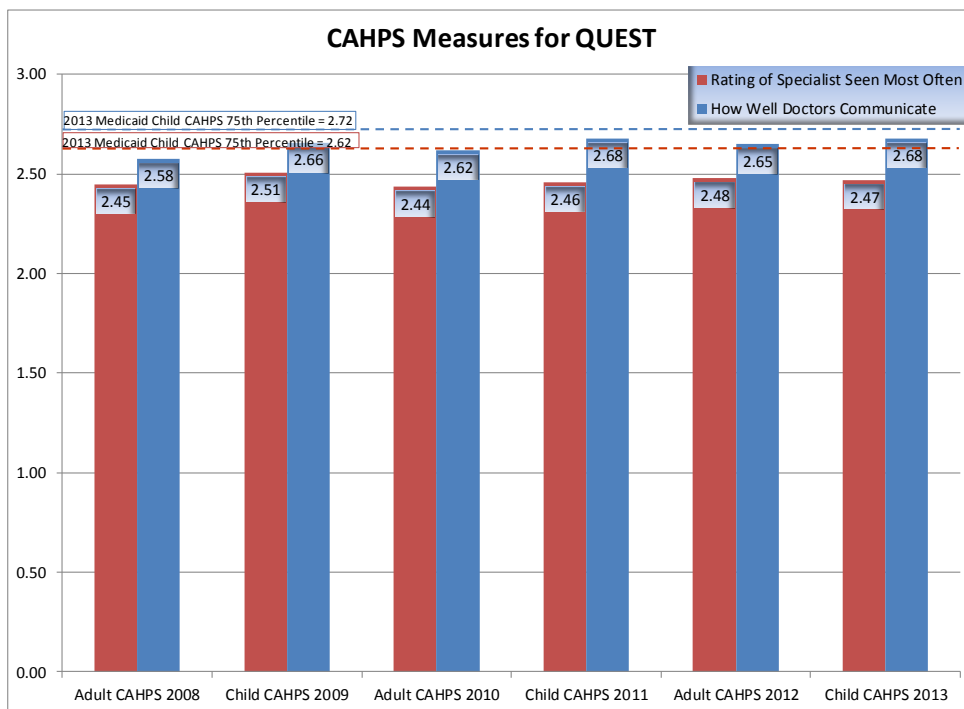
- The statewide CAHPS – Rating of Health Plan for the QUEST population varied between a high rate of 2.64 occurring in 2011 and the lowest rate of 2.40 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



- There is a clear up trend in the rates of the six years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show more of a bell curve, moving from 2.55 to 2.64 to 2.56.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.62 that was not exceeded by the 2.56 rate reported in 2013.

CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear up trend in the rates for the six years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a slight downward trend, moving from 2.65 to 2.68 to 2.62.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.65, which was slightly missed by the 2.62 rate reported in 2013.



CAHPS for QUEST – Rating of Specialist Seen Most Often:

- The statewide CAHPS – Rating of Specialist Seen Most Often for the QUEST population varied between a high rate of 2.51 occurring in 2009 and the lowest rate of 2.44 occurring in 2010. Note that alternating years have alternating

survey populations, either Adult or Child.

- There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46 to 2.47.
- The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.62 that was higher than all of the reported year.
- Improving the QUEST scores for CAHPS – Rating of Specialist Seen Most Often have involved: 1) Emphasizing telemedicine as an option for neighbor island clients seeking specialist services, 2) Increasing the frequency of specialists visits to neighbor islands, and 3) Implementing communication programs for physicians focused on skill building in the area of dealing with challenging situations.

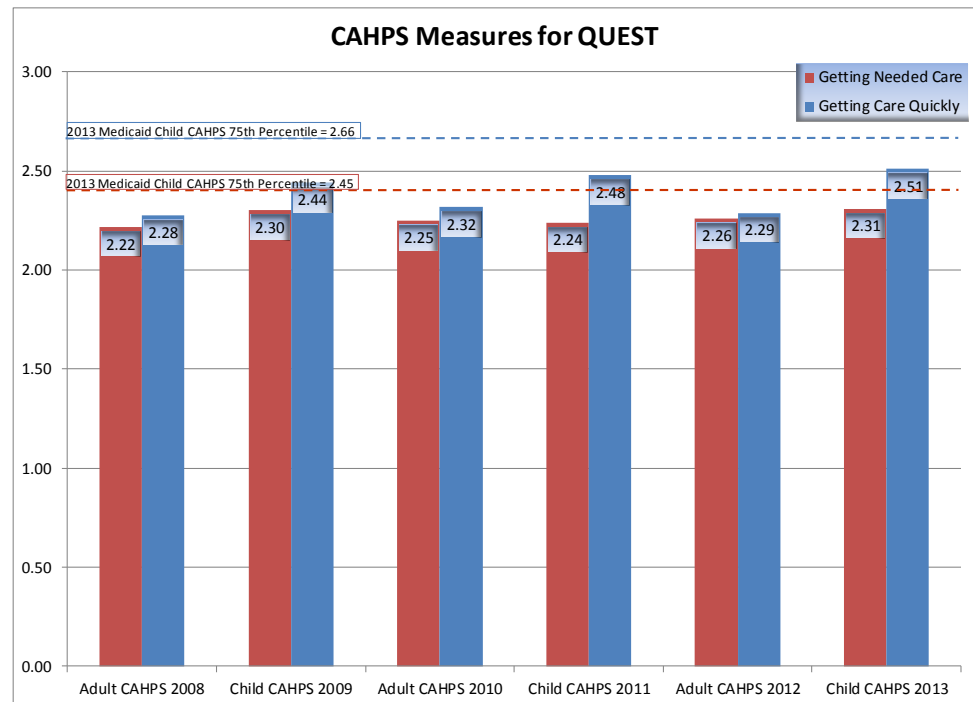
CAHPS for QUEST – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.68 occurring in 2011 and 2013 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is a clear up trend in the rates of the six years reported. Focusing on the Adult years, the rates move from 2.58 to 2.62 to 2.65. The Child years show a similar pattern, moving from 2.66 to 2.68 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.72 that was higher than all of the reported year.
- The QUEST plans have taken the following step to improve the CAHPS – How Well Doctors Communicate rates: 1) Improving the care coordination and communication between member and the primary care team.

CAHPS for QUEST – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QUEST population varied between a high rate of 2.31 occurring in 2013 and the lowest rate of 2.22 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



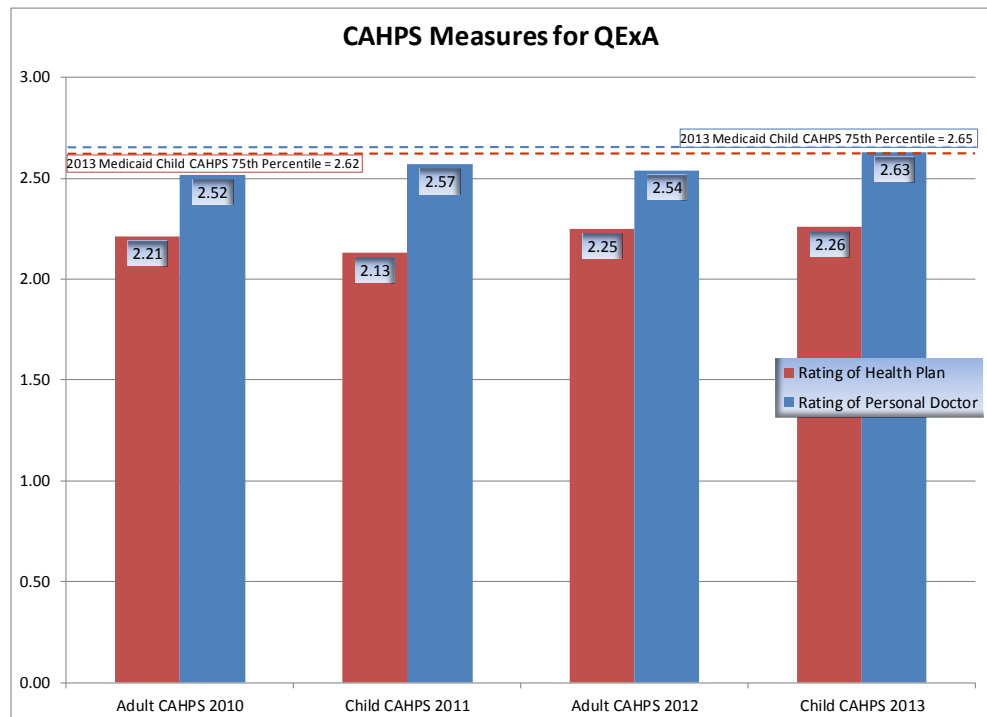
- There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern with a return to a higher rate in 2013, moving from 2.30 to 2.24 to 2.31.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.45 that was higher than all of the reported year.

CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.51 occurring in 2013 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48 to 2.51.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.66 that was higher than all of the reported year

CAHPS for QExA
– Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.26 occurring in 2013 and the lowest rate of 2.13 occurring in 2011. Note



that alternating years have alternating survey populations, either Adult or Child. Also note that the QExA program began in February 2009, which limits the number of data points.

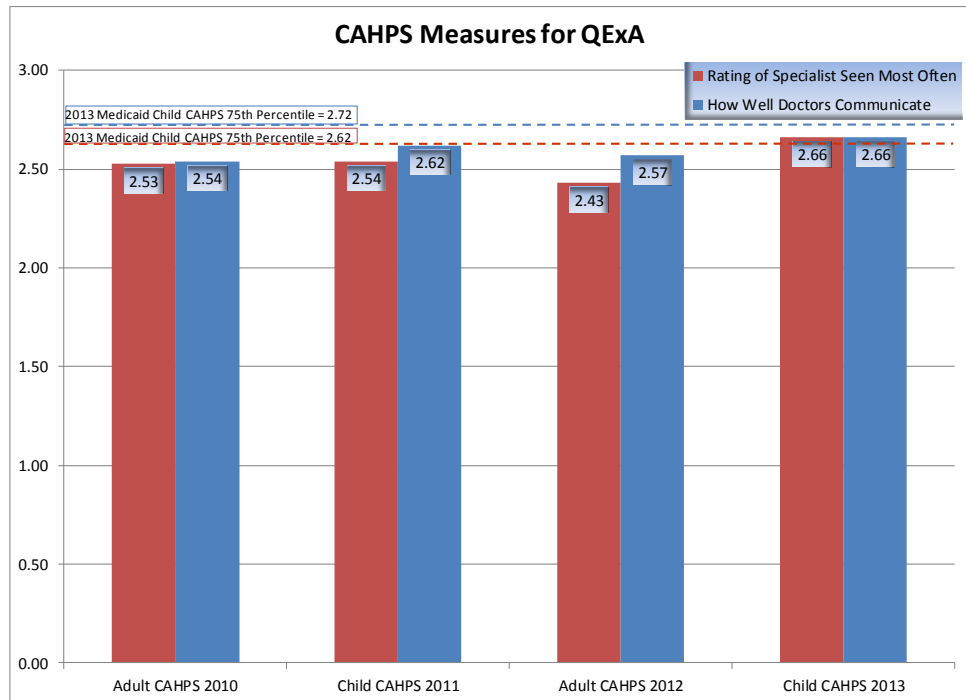
- There is a flat trend in the rates of the four years reported. The low point in 2011 (2.13) was the first data point for the Child population. The data for the Child population has increased in 2013 to 2.26.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2013 year this target was 2.62 that was better than all reported rates.

CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.63 occurring in 2013 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the first four years reported. The first three years lie within a 0.05 point window. However, in 2013, the rating has increased to 2.63 that is 0.6 points over the previous Child survey.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.65 that is higher than all of the reported years' rates.

CAHPS for QExA
 – Rating of Specialist Seen Most Often:

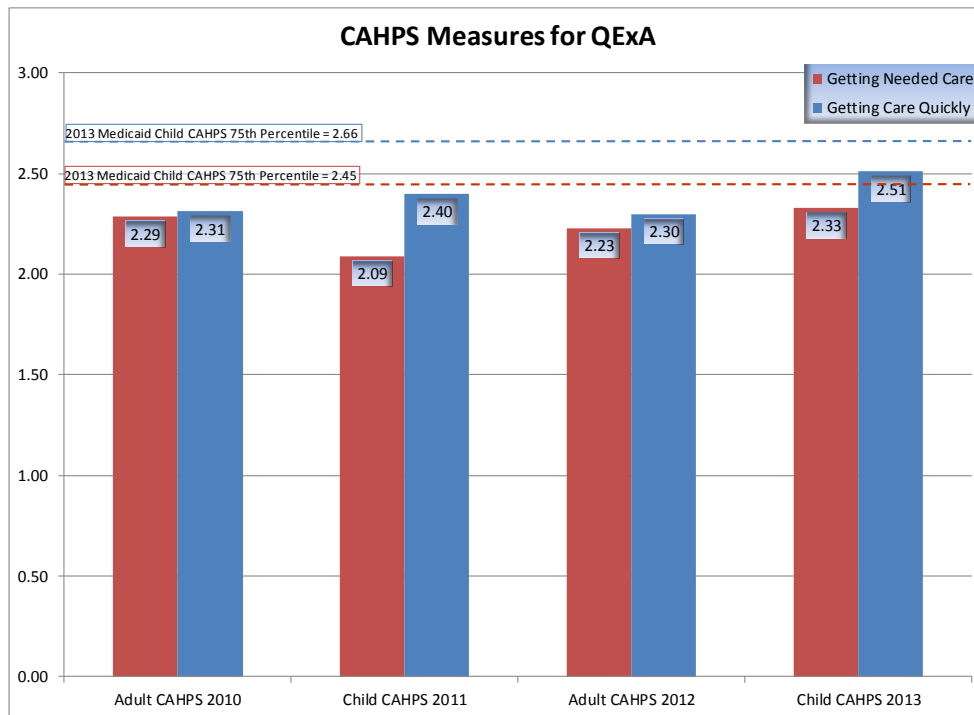
- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.66 occurring in 2013 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.



- The trend in the past year (2013) has increased over the previous four years.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.62 that was achieved in the Child survey in 2013 (2.66).

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.66 occurring in 2013 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- The trend in the four years reported is slightly increased. The Adult score moves from 2.54 to 2.57 from 2010 to 2012; the Child score moved from 2.62 to 2.66 from 2011 to 2013.
- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.72 that is higher than all of the reported year.



CAHPS for QExA – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QExA population varied between a high rate of 2.33 occurring in 2013 and the lowest rate of 2.09 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the Adult rates of 2010 and 2012; however, the Child rate is trending positively from 2011 to 2013 (from 2.09 to 2.33).
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.45 that is above each of the reported years.

CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.51 occurring in 2013 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.
- The Adult rates remained consistent from 2010 to 2012; the Child rates increased from 2.40 to 2.51 from 2011 to 2013.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.66 that is higher than all of the reported year.

Physicians' Assessment Measures

The Physician Assessment measures are included in this report to measure the degree of provider satisfaction with the Hawaii Med-QUEST program as well as the individual plans that contract with Med-QUEST to provide services to the QUEST recipients. The survey includes ONLY physicians and related professionals.

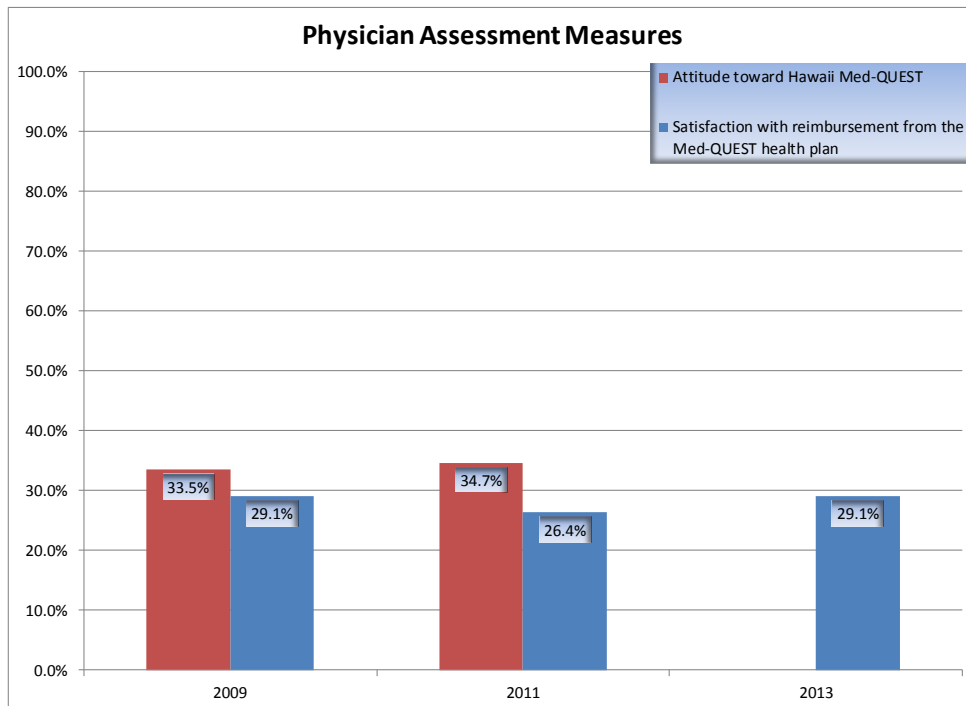
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall survey response rate was 30% in 2009, 26% in 2011, and 23% in 2013. These surveys are done every other year. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of years. Scores are reported for 2009, 2011, and 2013. Unfortunately, there are no national standards that can bring perspective to where we score on a national level.

For the Physician Assessment measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

Physician Assessment – Attitude Toward Hawaii Med-QUEST:

- The statewide Physician Assessment –Attitude Toward Hawaii Med-QUEST went from 33.5% in 2009 to 34.7% in 2011.



- With only two data points, a clear trend in the rates cannot be established.

- There are no National average percentages available for the Physician Assessment Measures.

- There are no results for 2013.

Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan:

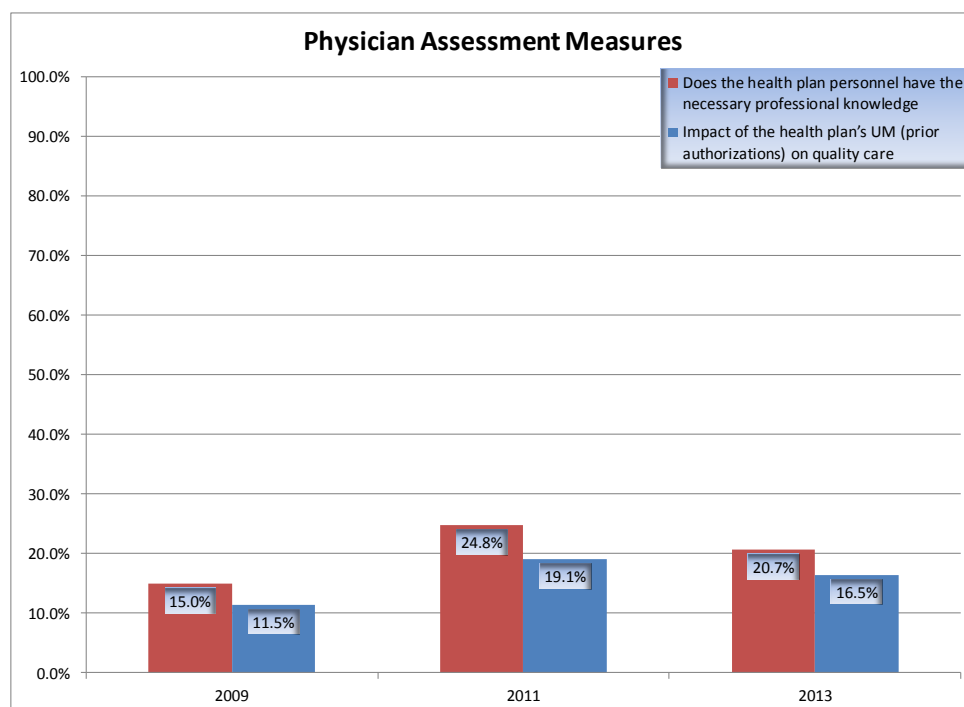
- The statewide Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan went from 29.1% in 2009 down to 26.4% in 2011 and back up to 29.1% in 2013.
- With only three data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% in 2011 and down to 20.7% in 2013.

- With only three data points, a clear trend in the rates cannot be established.

- There are no National average percentages available for the Physician Assessment Measures.



Physician Assessment – Impact of the health plan's UM:

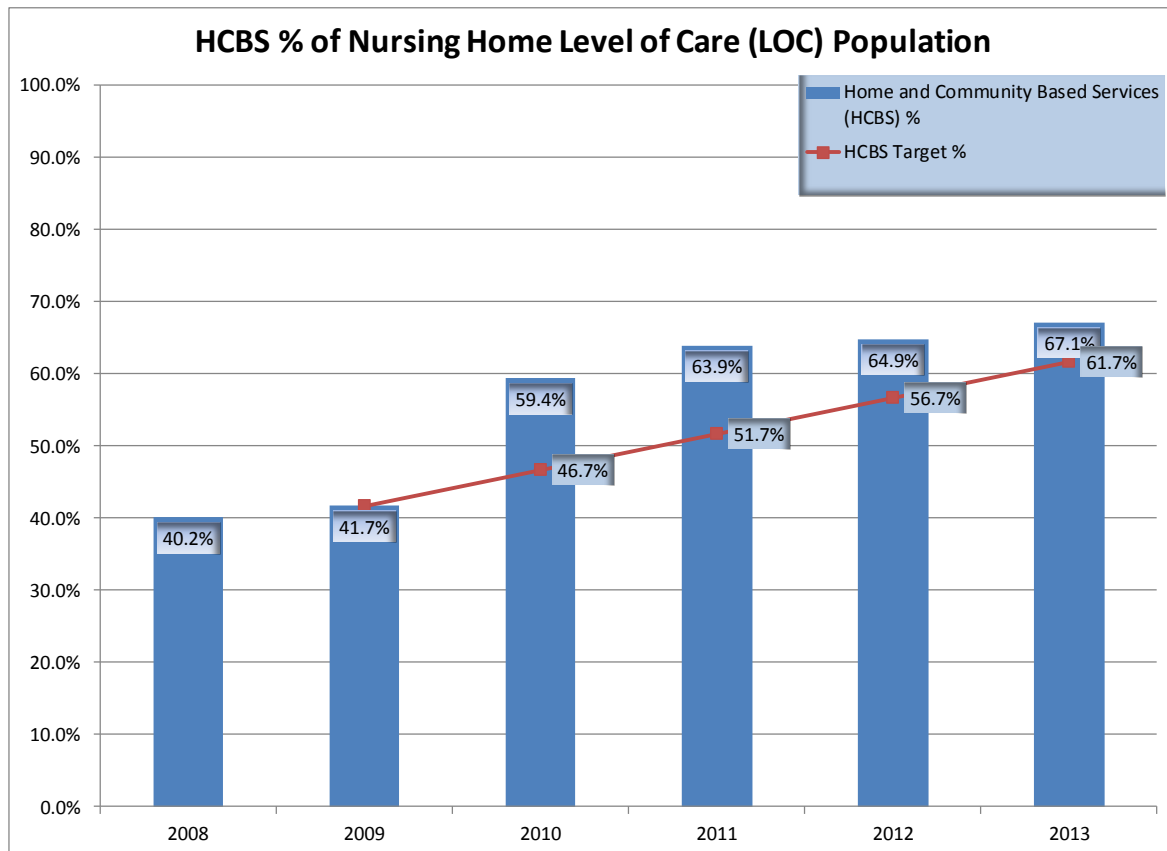
- The statewide Physician Assessment – Impact of the health plan's UM went from 11.5% in 2009 up to 19.1% in 2011 and back to 16.5% in 2013.
- With only three data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Med-QUEST Internal Measures

The Med-QUEST internal measures are included in this report to measure the financial aspects of the Hawaii Med-QUEST program. How is money being spent, and on how many and what type of recipients, is the focus of these measures.

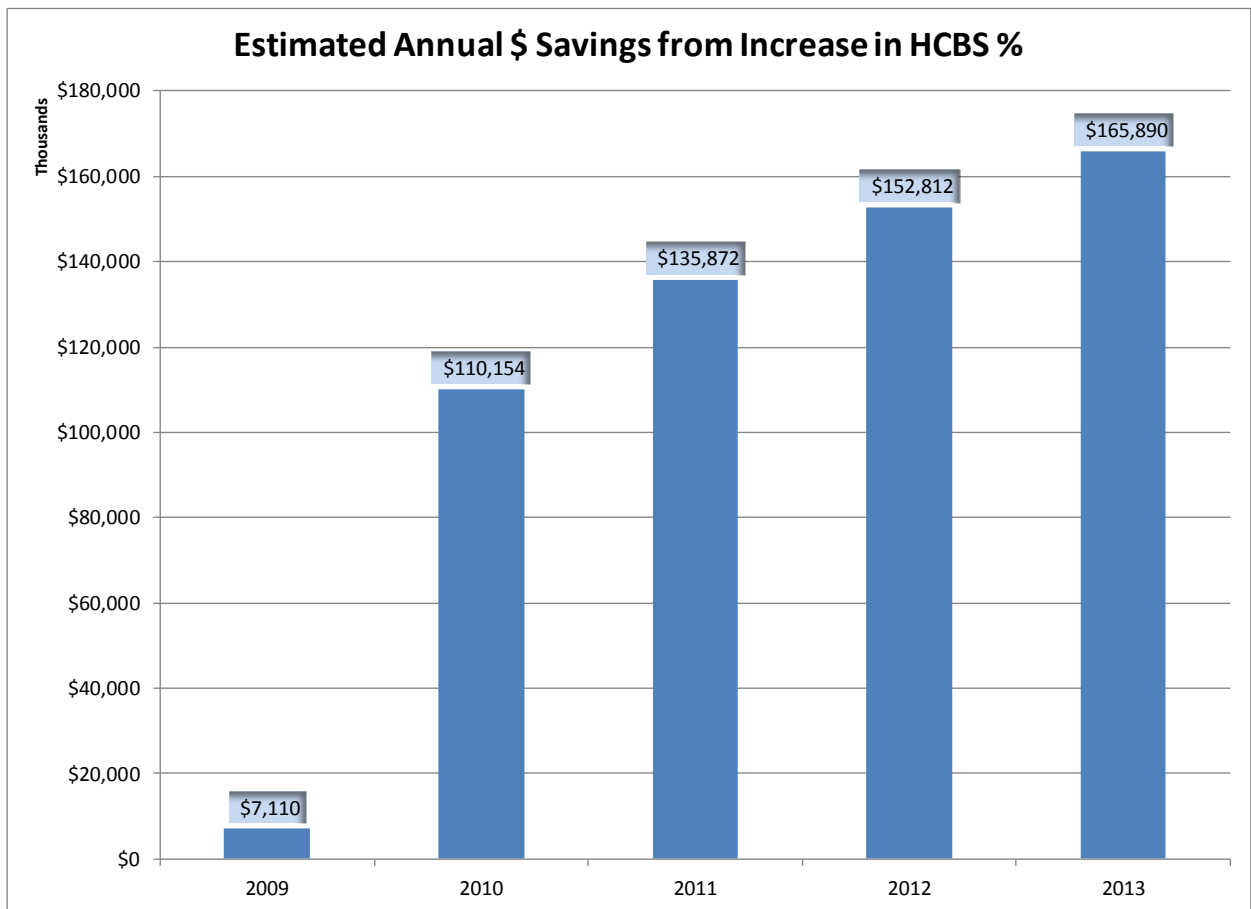
The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is an alternate service delivery model to traditional nursing home institutions. Instead of nursing home clients staying in an institution, they are out in the community and interacting. HCBS facilitate the continued social and mental stability of the client, as well as reduce the cost of serving this population. The average monthly \$ PMPM difference between a HCBS client and an institutional client was \$5,100 in calendar year 2013. We look at both the increase in HCBS % of the total nursing home LOC population as well as the MQD's cumulative annual dollars saving from this increase in HCBS %. The cumulative dollar savings is calculated by determining taking the difference between the current year's HCBS % and the 2009 HCBS%, multiplying it by the total nursing home LOC population to get a monthly savings figure, and then multiplying it by twelve to get an annual savings figure.

The member month measure used is a sum of member months, and will consist of entire populations based on reports run at the end of each month. The capitation payment file is a detail of all capitation payments made to each plan, and is the source of member month data. This file has enrollments for retro payments reflected in the month that payment was made. Initial months are paid pro-rated daily amounts based on the start date. Termination always occurs at the end of the month, except for retro termination for disability or death.



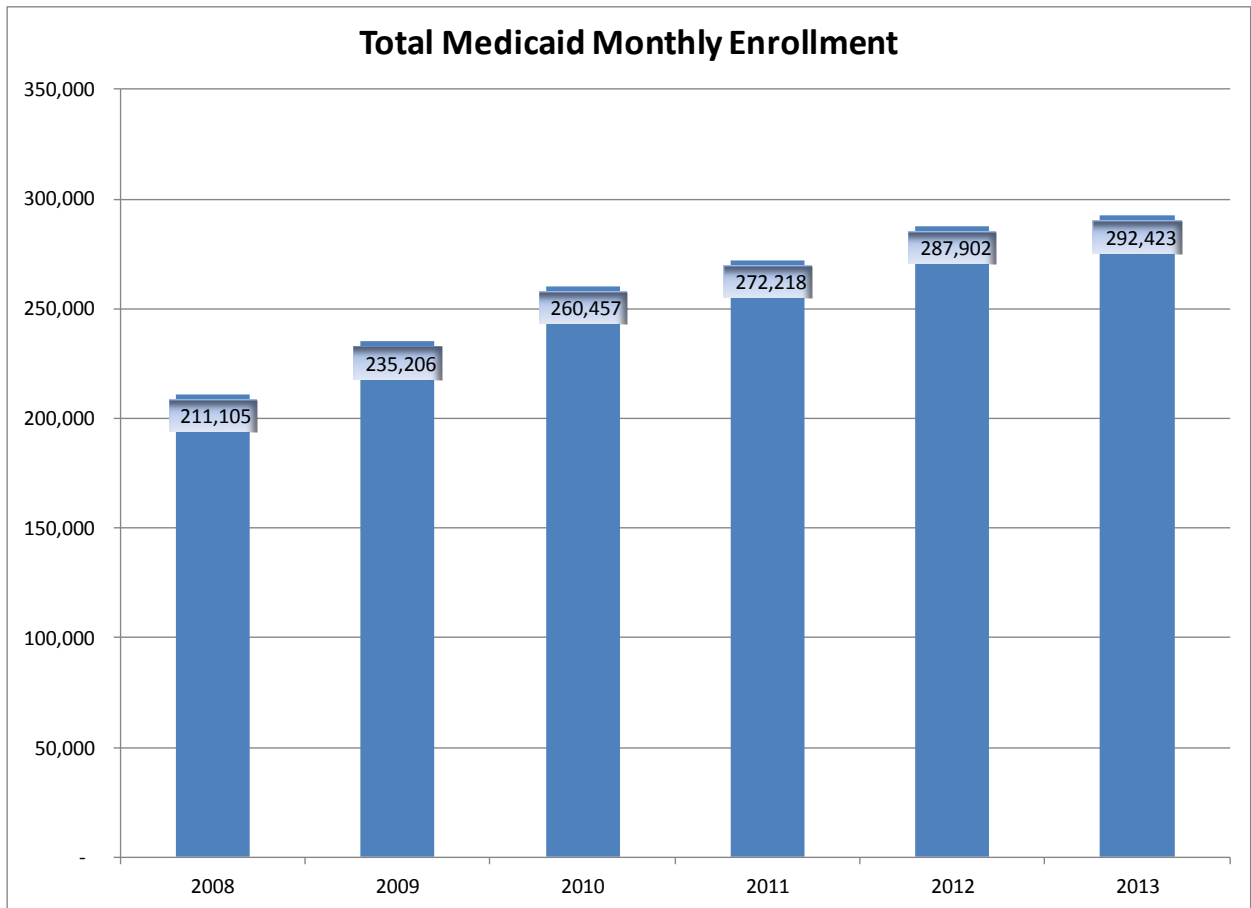
HCBS % of Nursing Home LOC Population:

- The statewide HCBS % of Nursing Home LOC Population went from 40.2% in 2008 to 67.1% in 2013.
- There is a clear upward trend in the rates. The QExA program began in February of 2009, and the largest percentage jump occurred between 2009 and 2010.
- Our Quality Strategy sets as a target a 5% per year increase in the HCBS % for our QExA program. Since beginning in February 2009 to the current year, this goal has been exceeded in each year.
- Prior to July 2010, the MQD had a fiscal incentive for the QExA health plans to move nursing home LOC clients from an institutional setting to a HCBS setting, which involved different capitation payments for HCBS vs. institutional settings. Beginning July 2010, the QExA health plans were paid a composite (average) capitation payment for all nursing home LOC clients, which changed the method of financial incentive in moving clients into an HCBS setting. This would explain the flattening off of the increases in percentage of clients that are in an HCBS setting.



Estimated Annual \$ Savings from Increase in HCBS %:

- The statewide Estimated Annual \$ Savings from Increase in HCBS % went from \$7,110,000 in 2009 to \$165,890,000 in 2013. The 2011 actual differential in \$ pmpm cost between institutional care and HCBS care is \$6,194.86, and this was used in the calculation of cost savings from 2009 to 2012. The new cost savings in 2013 is \$5,100. The reduction in savings is due to a reduction in institutional care expenses.
- Following the clear upward trend in the HCBS %, there is a corresponding cumulative increase in the dollars saved from this transition to HCBS.
- There is no National average available for dollars saved based on the move to HCBS.



Total Medicaid Monthly Enrollment:

- The statewide Total Medicaid Monthly Enrollment went from 211,105 in 2008 to 292,423 in 2013, which equates to an average annual increase of 7.7%.
- There is a clear upward trend in Medicaid enrollment, with each year logging consistent gains.
- There is no National average available for annual Medicaid enrollment increase.
- The Hawaii economy and unemployment rate in October 2013 (4.4%) is slightly above 2008 pre-recession levels (4.1%), causing the Hawaii Medicaid enrollment to continue to rise.
- With implementation of the Affordable Care Act (ACA), MQD expects a continued increase of enrollment.

Budget Neutrality Savings

Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the “With Waiver” expenditures are less than the “Without Waiver” expenditures, then Budget Neutrality Savings will result. The following table details the budget neutrality calculation through first quarter of Demonstration Year 20 (DY20) of the 1115 waiver. The overall total computable savings is \$2,666,917,523. An additional version of the Budget Neutrality information is found in Appendix A.

TOTAL COMPUTABLE		15	16	17	18	19	20
WITHOUT WAIVER	FMAP	1,648,275	1,679	1,656	1,581	1,512	1,516
		56,58X	67,35X	67,35X	51,79X	58,48X	51,86X
	MEC	16,19X	54,24X	64,32X	58,48X	51,86X	51,86X
		67,35X		62,93X			
	Correl						
	192 R 2						
	SHIP Children						
	Children	632,62	659,31	656,75	639,83	646,32	642,83
	Adults	654,38	638,81	639,18	673,87	673,18	674,34
	Agd	61,284,63	61,281,84	61,284,81	61,284,44	61,284,48	61,286,33
	Blind/Disabled	61,483,42	61,287,41	61,282,58	61,836,48	61,363,17	61,857,78
	Member Health						
	MEC						
	Correl						
	192 R 2						
	SHIP Children						
	Children	379,228	1,181,814	1,183,883	1,226,325	1,311,738	323,267
	Adults	348,185	338,484	421,378	429,365	465,888	162,883
	Agd	38,288	228,888	236,388	236,388	248,848	62,448
	Blind/Disabled	115,288	279,836	288,282	288,444	239,858	71,837
	Total Without Waiver Member Health	1,508,888	1,838,882	2,139,883	2,476,892	2,328,888	578,897
	Ceiling Without DSM	619,832,226	61,349,482,321	61,329,456,364	61,644,235,884	61,848,788,153	619,848,852
	DSM	687,546,858	687,285,819	674,358,243	673,542,655	675,688,533	677,281,886
	Total Ceiling	688,588,888	688,287,888	688,887,243	688,887,888	688,888,732	688,287,888
WITH WAIVER	1115	0	0	0	0	0	0
	192 R 2	0	0	0	0	0	0
	192 R 2X	0	0	0	0	0	0
	192 R 2	0	0	0	0	0	0
	APDC	0	0	0	0	0	0
	Agd w/Member	621,288,196	624,332,362	628,746,627	637,335,438	648,188,485	638,285,234
	Agd w/o Member	62,424,389	67,555,187	64,314,882	63,815,689	64,316,681	65,867,193
	D/D w/Member	671,734,335	674,849,259	681,283,856	677,888,222	685,424,232	682,682,376
	D/D w/o Member	681,514,842	674,789,336	678,388,228	673,833,193	678,377,836	678,351,551
	Special Cervical Cancer Treatment (BCCT)	162	64,853	646,332	638,465	674,823	677,323
	Correl	0	0	0	0	0	0
	CURRENT POP	0	0	0	0	0	0
	Correl Hawaii Overall	0	0	0	0	0	0
	Down Elig Adults	677,336,186	681,623,248	688,753,314	682,386,279	678,174,185	688,281,233
	Pauser Correl (19-21)	683,386	634,158	677,483	672,849	678,816	676,323
	Hawaii Overall (192)(R)(2)	626,332	68,881	0	0	0	0
	HCCP	688,153	0	0	0	0	0
	Health Overall Correl	0	0	0	0	0	0
	Health Overall Others	0	0	0	0	0	0
	Med Headz Adults	628,345	617,885	618,837	68,385	0	0
	Med Headz Children	67,715	63,388	0	0	0	0
	MFCP	628,159	0	0	0	0	0
	MH w/w	616,133,737	0	0	0	0	0
	Opt/SP/Children	627,166	623,182	621	0	0	0
	Others	0	0	0	0	0	0
	Others Hawaii Overall	0	0	0	0	0	0
	OthersX	0	0	0	0	0	0
	QUEST ACE	614,352,158	623,872,248	638,473,416	627,842,675	638,843,234	627,611,257
	RHACP	617,432,343	0	0	0	0	0
	SIPI Adults-Program/COFA	0	624,338	62,628,848	62,625,511	62,727,281	629,444
	State Plan Adults	618,225,118	618,138,152	614,232,319	613,183,715	618,812,286	623,455,271
	State Plan Children	618,823,245	628,887,156	621,614,281	618,884,276	618,822,286	648,365,624
	Supp - Private	0	0	0	0	0	0
	Supp - State Gen.	0	0	0	0	0	0
	UCC-Governor/L	616,356,588	624,287,485	614,884,431	618,833,842	612,164,873	63,813,846
	UCC-GOVT LTC	0	0	0	0	0	0
	UCC-Private	67,288,888	67,288,888	67,288,888	0	638,818,619	613,367,181
	Total Expenditures Per CMS-64 Waiver	6785,828,888	61,249,239,464	61,358,837,374	61,239,629,884	61,264,769,888	6388,489,523
	Private Share (Not reported on 64 Waiver)	-61,212,882	-63,237,231	-63,476,611	-63,375,153	-63,277,831	-63,218,145
	Total Expenditures	6788,886,887	61,186,002,233	61,295,360,763	61,176,254,731	61,198,492,057	6385,271,378
	DY 20 Savings	6826,332,833	6288,275,492	6288,386,583	6476,589,784	6472,821,833	6266,658,321
	Commutative Savings	6723,391,643	61,847,267,855	61,355,853,553	61,132,467,369	61,132,467,369	62,666,317,523
		-622,287	-61,345,437	-61,835,281	-61,164,338	-61,626,446	-61,318,845
		-613,277	-61,517,346	-61,185,118	-61,388,862	-61,343,336	
	Medicaid Rebalancing benefit during year 15	-622,287	-61,583,823	-61,355,837	-61,355,888	-61,753,318	

QUEST Expanded Member Months

The most basic measure of how many members you are impacting through your waiver program is member months. The capitation payment file, which is a detail of all capitation payments made to each plan, is used to calculate these figures. These amounts represents paid member month through September 30, 2013. A detailed copy of the member months may be found in Appendix B.

Expenditures for QUEST-ACE Program

The QUEST Adult Coverage Expansion (QUEST-ACE) is program that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in §17-1727-26. The enrollment cap for this program was originally set by CMS at 12,000. In addition, the QUEST-ACE benefit package was the same limited package of benefits provided under the QUEST-Net program, which includes limited medical benefits. A childless adult under the QUEST-ACE program is defined as a person who is:

- Between nineteen years of age through age 64;
- Is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement; and
- Does not have a dependent child in the home.

QUEST-ACE started offering coverage for recipients on April 1, 2007. Financial expenditures for QUEST-ACE beneficiaries are \$30.4M, in DY 17, \$27.8M in DY18, \$50M in DY19and \$17.6M for the first quarter of DY20. More information on QUEST-ACE expenditures may be found in Budget Neutrality calculations in Appendix A.

Recent Initiatives on Measures

The following section will discuss initiatives that the health plans have taken recently to improve the rates of the various measures discussed above.

HEDIS Initiatives

Use of Appropriate Medications for People with Asthma (ASM) Initiatives:

- Implemented health education programs for asthma and physician/patient education on medication.
- Provided community education and outreach activities.
- In 2012, one health plan implemented pay-for performance for HEDIS ASM (age5-20) and (age21-64) for child and adult primary care providers.

Comprehensive Diabetes Care (CDC) Initiatives:

- Is an MQD Quality Strategy measure.
- Improving the health of members with diabetes is a focus in MQD's Quality Strategy. CDC – LDL < 100 mg/dL is a QUEST pay for performance measure.
 - One health plan has allocated \$1.75 million each year for the past 3 years in a QI Incentive Program to provide support for provider-based quality improvement projects and to reward quality improvements. In 2012 this health plan implemented pay-for performance for the following HEDIS CDC measures: Eye exam, HbA1c control, and LDL-C control.
 - One health plan implemented a Panel Support Tool (PST) that is used consistently by the PCP team to flag needed prevention and chronic disease gaps for each member at the point of care. This includes labs that are due (e.g., HbA1c, LDL) and recommended adjustments in medications for labs that are not at goal (e.g., adjustment of orals or addition of insulin for HbA1c or LDL labs that are not at goal). The PST is also used for population management to allow the PCP team to outreach to members who are not coming into the clinic.
- Implemented health education programs for a variety of diabetes-related issues, including healthy eating and weight loss programs, monitoring of alcohol consumption, smoking cessation programs, and physician/patient education on medication. This includes both written and electronic health education materials.
 - In 2011, one health plan reported more members have participated in their Health Media: Care for Diabetes, which is an online program that is free to their members. The program is customized specifically by assessing a member's daily routine, general health and providing ways to manage their diabetes more effectively. The

- member receives follow-up emails to track their progress. After completing a questionnaire, the member receives an action plan and tools that are tailored to their preferences, and their willingness and ability to use them. The member can review their plan online, or print a copy to discuss with their physician at the next office visit.
- One health plan reported that diabetes education classes are still available to all individuals at-risk of developing diabetes and individual with diabetes. PCP teams refer members to these classes to receive education about diabetes, including teaching about diet, exercise, medications, and labs, among other topics. These are taught by health educators, dietitians, and nurses. More recently, the diabetes classes are also teaching self-monitoring with glucometers and insulin starts if needed. Nurses continue to be available to the PCP team to provide urgent teaching for glucometers and insulin starts.
 - Implemented reminder systems to inform diabetics of needed preventive services and to contact non-compliant members using letters and/or calls. Several health plans also inform providers of members who were overdue for preventive visits and screenings.
 - Provide outreach to diabetics by identifying new diabetic members in a new welcome call assessment. One health plan also sends a letter and diabetes member toolkit, called the “ABCs of Diabetes” to all members who were identified as having diabetes. This toolkit included an educational brochure and diabetes checklist for members to use in managing their diabetes.
 - One health plan is starting automated batch ordering of labs for members with diabetes every six months. Automated recorded reminders were also started for members with overdue labs, in addition to calls made by an outreach team. These steps gave added assurance that members with diabetes are not overlooked in terms of their routine labs.
 - One health plan’s outreach team has been focusing on its Medicaid members with diabetes to provide the additional assistance to the PCP team, regardless of whether the member has been referred to the outreach team. In addition to placing reminder calls about labs, the outreach team also assists in titrating medications to get HbA1c and LDL levels to goal. The outreach team has also started to ensure that Medicaid members with diabetes have a three (3) month supply of medications to increase compliance.
 - Distributing periodic newsletters with diabetes articles and updates.
 - Offer provider training on the importance of tracking Body Mass Index (BMI) of their patients with diabetes as well as offering nutrition and physical activity counseling.

Cholesterol Management for Patients with Cardiovascular Conditions (CMC) and Controlling High Blood Pressure (CBP) Initiatives:

- Provided education to member and provider to increase awareness of cholesterol management and the importance of medication compliance.

- One health plan has a team composed of nurses and pharmacists that provides support to individuals with cardiovascular disease. This team helps to contact members who are due for labs and/or medication pick-up and assists PCP teams with titrating medications to bring members to goal.
- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.
 - One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.
 - One health plan implemented a “Hospital to Home” care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member’s understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member’s case.

Childhood Immunization Status (CIS) Initiatives:

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.
- Offered provider education and assistance to help bridge gaps in member care and compliance.
- Established patient reminder and recall systems that include postcard and telephone reminders to non-responders for missed appointments and/or immunizations.
 - One health plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.
- Conducted regular assessments of immunization rates.
 - One health plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the ‘How Are We Doing Reports’ and conducts systems and process improvement recommendations for underperforming clinics.
- Implemented provider incentives and/or a comparison of performance to a goal or standard.

- Several health plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.
- Health plans implemented mechanisms to obtain data from two major laboratory vendors. In addition, physicians are entering immunization data into health plan's quality monitoring system.
- One health plan is matching all laboratory claims data with reports that are given by the laboratory vendors to assure that they are receiving adequate information.

Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), & Chlamydia Screening in Women (CHL) Initiatives:

- Implemented reminder systems that inform patients of upcoming mammogram, cervical cancer screening appoints and eligible females who have not received a screening for Chlamydia in the recommended time frame.
- Reduced barriers that may be preventing the patient from receiving a mammogram.
 - One health plan reports success with their Mobile Health Vehicle and plans to expand this service in 2012 to include diagnostic breast imaging in addition to screening mammography
 - One health plan is trialing evening outreach for pap appointments and focusing pap clinics in areas with highest screening needs.
- Improved the capture of screenings for members who have been screened.
 - One health plan executed contract amendments with the two main laboratories in Hawaii to assure lab results' supplemental data are obtained for those performance measures which require a result determination.
 - One health plan receives supplemental data from an FQHC that does not submit claims to the health plan for Chlamydia screening. The health plan obtains a list of members who have received a screening as well as a sample of the Electronic Health Records for primary source verification, which is then reviewed by an auditor for compliance. This supplemental data had a positive impact on the 2011 HEDIS rate as there was an increase of 10% in the number of members receiving a Chlamydia test during the measurement year for the QUEST population.

Ambulatory Care (AMB) Initiatives:

- Implemented education of members on appropriate ER use.
 - One health plan provided intervention for high utilizers with active case management by clinicians and case managers. Case managers assigned to these members directed them to appropriate care, ensuring that the patient has an assigned PCP, identified any

barriers in care, reason for frequent visits to the ER and provided education on appropriate use of the ER.

- One health plan has Disease Management staff address care gaps during the assessment process and follow-up calls, in addition to supporting and reminding members of the importance of complying with disease management recommendations.

CMS-416 EPSDT Measures Initiatives

In 2011 health plans began receiving aggregated reports based on Hawaii EPSDT forms that contained the following information: BMI metrics, immunizations, screenings, referrals, care coordination, and abnormal screenings. These reports will assist the health plans in determining gaps in EPSDT visits/screenings, and to follow-up with referrals and care coordination.

CAHPS (QUEST & QExA) Initiatives

Rating of Health Plan & Rating of Personal Doctor Initiatives:

- Utilized online and technology assets to outreach to members.
 - One health plan launched a new Health & Wellness section on its website, along with notifying member of this new section.
 - One health plan updated their secure member portal, to add functionality to include ordering and printing ID cards, change PCPs, and update demographic information.
- Used face-to-face meetings to assess and evaluate the membership experience with the health plan.
 - One health plan conducted member education sessions on various health topics as well as emphasizing the need to communicate with their doctors.
 - One health plan conducted quarterly focus groups to gain a better understanding of the member needs, expectations and dissatisfactions.
- Utilized “hard copy” media to outreach to the member and increase member satisfaction with the health plans.
 - One health plan sent out members-specific letters detailing preventive visits and screenings or tests that are coming due, as well as an explanation as to the necessity of these visits.

- One health plan created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.
- Conducted an internal review of information flow to improve health plan responsiveness to member problems.
 - One health plan recently improved its process to reimburse dual-eligible members for erroneously paid co-pays. Service coordinator and call center staff were re-trained to follow new protocols to speed the identification and reimbursement to the member. Provider education was provided on appropriate billing for dual-eligible members to prevent this from occurring in the first place.

Rating of Specialist Seen Most Often & How Well Doctors Communicate Initiatives:

- Utilized online and technology assets to outreach to provider to improve care delivery.
 - One health plan made available members' HEDIS care gaps to providers via secure online content. Providers could then close these recommended care gaps with their members.
- Incentivized providers to improve care.
 - One health plan offered \$100 per member incentives to providers to complete care gaps for dual eligible members.

Getting Needed Care & Getting Care Quickly Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.
 - One health plan streamlined the provider search functionality on their website.
 - One health plan increased the update frequency of the online provider directories to daily.
 - One health plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.
 - One health plan added online 'enter' and 'view' functionality for prior authorizations, admissions and referrals
- Reached out to members to gauge provider access and care delivery.
 - One health plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.

- One health plan conducted ongoing member surveys to further gauge timely access to care.
- Personally assisted members with obtaining needed provider appointments.
 - One health plan coordinated the scheduling of appointments for “hard to find” specialists such as Neurosurgeons, Pulmonologists, Gastroenterologists, etc. when the member was having a difficult time doing this on their own.
 - One health plan encouraged open access scheduling models at physician offices, where part of the physician’s schedule is left open for same-day patient access or urgent visit reservations.
 - One health plan merged systems that track gaps in HEDIS-related care with customer service, so that during member calls the customer service rep can remind the member that they need to see a provider and even offer to set up an appointment.
 - One health plan implemented a Complex Case Management program to assist members that have experienced a critical event or diagnoses that requires extensive use of resources. This program provides a comprehensive assessment of the member’s condition, development and implementation of a care plan, and monitoring and follow-up with the member’s PCP.
- Other miscellaneous improvements were made.
 - All of the health plans simplified the drug prior authorization process by standardizing the form across all Medicaid members.
 - One health plan made physician biography cards available at clinic locations to facilitate physician comparisons and selection.
 - One health plan allocated \$300,000 over the past four years to support recruitment and retention of providers, particularly on the neighbor islands.
 - One health plan implemented a 24-hour nurse triage call line equipped with specialty trained nurses and an audio health library.
 - One health plan added the ability of QUEST members to email the plan’s QUEST department directly from the health plan website.
 - One health plan began implementation of Patient-Centered Medical Homes in key FQHCs. A data analyst and care advocate works with the FQHC to provide data on care opportunities, and to assist with coordination of care related to these opportunities.
 - One health plan expanded their use of telemedicine. Though this health plan continues to send Oahu specialists to other islands, telemedicine has proven especially useful for members on other islands by reducing the need for travel to

Oahu. This has also resulted in increased member satisfaction of specialty care and access for member health care.

Physicians' Assessment Initiatives

Attitude Toward Hawaii Med-QUEST & Satisfaction with Reimbursement from the Med-QUEST Health Plan Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.
 - One plan created a centralized email inbox to streamline provider inquiries to the health plan's provider relations department, including reimbursement and claim issues.
- Created internal advocacy for provider needs and interests.
 - One health plan started a Provider Advisory Group within the Health Plan to take the provider's point of view, and to review new provider forms and programs.

Does the Health Plan Personnel have the Necessary Professional Knowledge & Impact of the Health Plan's UM (prior authorizations) on Quality Care Initiatives:

- Improved the knowledge base of their employees through various training modalities.
 - One health plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.
 - One health plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
 - One health plan increased staff coaching and mentoring activities.
 - One health plan conducted monthly knowledge quizzes to gauge whether additional training is needed.
- Initiated improvements to the prior authorization process.
 - One health plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
 - One health plan added an online PA application to streamline the PA process.
 - One health plan increased provider training and education related to the online PA process.

- One health plan distributed handouts on the PA process during periodic provider relations visits.
- One health plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
- One health plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
- One health plan reviewed the compliance to the health plan’s clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

Plan All-Cause Readmission Initiatives

- One health plan implemented the Hospital Utilization Readmission Reduction Team (HURRT), that includes an interdisciplinary team of clinical staff (medical, social work, and behavioral health), managers, and medical directors (medical and behavioral health) to review the “super utilizers” (i.e., top 1 percent of utilizers, complex medical/behavioral health cases). Case reviews are presented on the members most frequently readmitted to the hospital and/or with the highest ER usage and provide a comprehensive recommendation to the specific service coordinator/case manager to incorporate in the member’s care plan. This health plan reports that it has seen a decrease in readmission rates for those members who had interventions through this interdisciplinary team.
- One health plan implemented a new 30-day hospital readmission program called AHOP (After Hospital Outreach Program) targeting members with congestive heart failure to help prevent hospital readmissions. Interventions include health education, follow-up appointments, transportation, and collaboration with PCP.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
 - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to “get into a waiver.”
 - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
 - Choices offered include:

- Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
 - Residential settings such as community care foster family homes or assisted living facilities
 - Institutional setting
- Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
- DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation
- Standardized assessment tools for HCBS
 - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
 - The use of these assessment tools have helped to streamline receipt of services

Hawaii Medicaid Enrollment Initiatives

- MQD is focused on assuring processing of applications for Medicaid within 45-days or else providing presumptive eligibility.
- MQD has enacted eligibility for beneficiaries' five-days prior to submittal of application to assure that medical services received will be covered.
- MQD has amended its 1115 demonstration waiver to provide eligibility up to 133% of Federal Poverty Level to be prepared for implementation of ACA.

Recommendations

Though the MQD has seen improvement in many of its performance measures over the past six years, we are not meeting all of the requirements that we have established in our Quality Strategy of at least 75th percentile of the national Medicaid population. MQD has the following recommendations for improving health plan performance:

1. Improve process for gathering information from providers

The majority of Medicaid providers in Hawaii are single providers (i.e., not part of a group practice and are not part of an Independent Physician Association (IPA)). In addition, up to this point, both the QUEST and QExA health plans provide information to Hawaii Medicaid providers retrospectively. It has been very difficult to make changes in HEDIS results for critical areas such as diabetes or cardiovascular disease when the penetration into the provider community is provider-by-provider.

Some recommendations for the future are:

- A. Encourage providers to move to electronic medical records and achieve meaningful use by implementing the Electronic Health Record (HRE) initiative that is part of the ACA.
- B. Offer reminders to providers in real-time for best practices (i.e., reminders for preventative screenings).

2. Explore mechanisms to improve health plans' supplemental data collection

Health plans have identified that immunizations and certain screenings like Chlamydia are often performed and paid for outside the health plan. Therefore, these services are not captured for coordination of care or for reporting in the health plan's HEDIS measures. MQD is committed to support and encourage collaborative endeavors by the health plans to work with FQHCs and other large providers to obtain data for services paid through federal grants for Medicaid members.

3. Increase the Pay for Performance withhold from health plans

MQD implemented a Pay for Performance (P4P) withhold from the QUEST program in 2010. In this program, MQD withheld \$1.00 PMPM for every capitation payment for each member that has been with them for the entire month. Annually, MQD reviews the health plans' HEDIS and CAHPS results compared to 75th percentile of the national Medicaid population as well as look to see if they have improved their results by at least 50% over the past year. If a health plan has met one of the desired results, then they receive a payment of \$0.20 PMPM for each performance measure they have met.

MQD increased the P4P withhold to \$2.00 PMPM to encourage the health plans to strive for quality in the care they are providing to their members. In addition, payment of the P4P is based solely on meeting 75th percentile of the national Medicaid population.

4. Implement auto-assignment percentages based upon results of HEDIS and CAHPS results

In the current QUEST contract effective July 1, 2012, MQD revised the auto-assignment percentages based upon results of HEDIS and CAHPS results. These auto-assign percentages will be revised annually based upon previous year results. The first auto-assign percentages will be implemented on July 1, 2014.

Conclusion

MQD has seen some improvement in the results of the program over the past six years. However, additional changes are required to assure better preventative screening and disease treatment of our beneficiaries. Through implementation of the recommendations provided, MQD anticipates improved health plan performance and better quality of services to our beneficiaries.

Appendix A

Hawaii 1115 QUEST Waiver		14	15	16	17	18	19	20
TOTAL COMPUTABLE WITHOUT WAIVER						<i>Renewal</i>		
	FMAP	0.567625	0.640275	0.6735	0.6546	0.5081	0.5152	0.5186
		57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%
MEG	MEG Description and Comments	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.86%
			67.35%		62.63%			
Current 1902 R 2	TANF (AFDC), Foster Children, GA children SHIP Children							
Children	TANF (AFDC), Foster Children, GA children, SHIP Children	\$302.59	\$322.62	\$343.98	\$366.75	\$391.03	\$416.92	\$421.09
Adults	TANF Adults	\$531.07	\$564.90	\$600.88	\$639.18	\$679.87	\$723.18	\$749.94
Aged	Aged		\$1,204.63	\$1,281.84	\$1,364.01	\$1,451.44	\$1,544.48	\$1,596.99
Blind/Disabled	Blind/Disabled		\$1,489.42	\$1,597.11	\$1,712.58	\$1,836.40	\$1,969.17	\$2,057.78
Member Months								
	MEG							
Current 1902 R 2	TANF (AFDC), Foster Children, GA children SHIP Children							
Children	TANF (AFDC), Foster Children, GA children, SHIP Children	891,143	979,228	1,101,814	1,183,803	1,226,925	1,311,730	323,267
Adults	TANF Adults	302,135	348,185	390,404	421,978	423,965	466,880	112,889
Aged	Aged		98,208	228,008	236,980	236,986	248,848	62,418
Blind/Disabled	Blind/Disabled		115,268	273,836	288,282	288,441	293,050	71,897
	Total Without Waiver Member Months	1,193,278	1,540,889	1,994,062	2,131,043	2,176,317	2,320,508	570,471
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	\$435,286,898	\$819,052,526	\$1,343,482,321	\$1,523,456,964	\$1,644,295,004	\$1,848,708,159	\$469,048,052
DSH		\$83,856,667	\$87,546,360	\$89,735,019	\$91,350,249	\$93,542,655	\$95,600,593	\$97,703,806
Total Ceiling		\$519,143,565	\$906,598,886	\$1,433,217,340	\$1,614,807,213	\$1,737,837,659	\$1,944,308,752	\$566,751,859
WITH WAIVER								
	1115	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2X	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902R2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	AFDC	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Aged w/Mcare	(\$295)	\$121,280,136	\$314,952,962	\$350,714,627	\$327,535,438	\$348,180,485	\$90,705,294
	Aged w/o Mcare	\$0	\$2,424,989	\$17,555,107	\$24,914,002	\$19,815,683	\$24,316,601	\$5,867,119
	B/D w/Mcare	(\$13,736)	\$31,794,935	\$74,849,759	\$81,263,856	\$77,060,222	\$85,421,592	\$22,602,376
	B/D w/o Mcare	(\$28,991)	\$81,514,842	\$211,789,936	\$248,908,528	\$252,833,113	\$278,377,896	\$68,957,661
	Breast Cervical Cancer Treatment (BCCT)	\$0	(\$2)	\$4,053	\$545,332	\$905,465	\$748,923	\$177,932
	Current	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	CURRENT POP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Current-Hawaii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Demo Elig Adults	\$154,645,707	\$177,396,186	\$201,629,248	\$238,769,914	\$242,386,279	\$210,174,105	\$40,782,219
	FosterCare(19-20)	\$91,499	\$83,366	\$94,158	\$137,403	\$72,849	\$105,016	\$36,929
	HawaiiQuest-1902(R)(2)	\$33,061	\$26,332	\$8,001	\$0	\$0	\$0	\$0
	HCCP	\$135,520	\$683,159	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Current	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Med Needy Adults	\$115,693	\$58,345	\$117,005	\$109,837	\$8,305	\$0	\$0
	Med Needy Children	\$0	\$7,715	\$3,960	\$0	\$0	\$0	\$0
	MFCP	\$122,839	\$581,513	\$0	\$0	\$0	\$0	\$0
	NH w/o W	\$5,100,418	\$16,199,737	\$0	\$0	\$0	\$0	\$0
	Opt St Pl Children	\$80,075	\$257,166	\$253,182	\$31	\$0	\$0	\$0
	Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Others-Hawaii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	OthersX	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	QUEST ACE	\$5,696,094	\$14,352,538	\$23,872,210	\$30,473,416	\$27,842,675	\$50,043,394	\$17,611,257
	RAACP	\$7,862,479	\$17,432,949	\$0	\$0	\$0	\$0	\$0
	St Pl Adults-Preg Immig/COFAs	\$0	\$0	\$24,990	\$2,628,840	\$2,625,611	\$2,777,381	\$634,444
	State Plan Adults	\$109,034,691	\$128,225,118	\$132,190,152	\$124,252,313	\$113,189,715	\$120,812,586	\$29,455,721
	State Plan Children	\$155,394,271	\$168,853,245	\$203,887,136	\$215,614,781	\$185,884,276	\$192,822,506	\$40,965,624
	Supp. - Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Supp. - State Gov.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	UCC-Governmental	\$18,919,184	\$16,356,580	\$24,507,605	\$34,064,491	\$48,859,842	\$12,164,879	\$3,019,846
	UCC-GOVT LTC	\$0	\$0	\$0	\$0	\$609,561	\$0	\$0
	UCC-Private	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$0	\$38,818,619	\$19,367,101
Total Expenditures Per CMS-64 Waiver		\$464,688,509	\$785,028,849	\$1,213,239,464	\$1,359,897,371	\$1,299,629,034	\$1,364,763,983	\$340,183,523
Premium Share (Not reported on 64 Waiver)		-\$660,309	-\$4,962,002	-\$38,297,536	-\$43,476,661	-\$38,375,159	-\$38,277,091	\$9,910,015
Total Expenditures		\$464,028,200	\$780,066,847	\$1,174,941,928	\$1,316,420,710	\$1,261,253,875	\$1,326,486,893	\$350,093,538
DY BN Savings		\$55,115,365	\$126,532,039	\$258,275,412	\$298,386,503	\$476,583,784	\$617,821,859	\$216,658,321
Cummulative Savings		\$672,659,605	\$799,191,643	\$1,057,467,055	\$1,355,853,559	\$1,832,437,343	\$2,450,259,202	\$2,666,917,523
		-\$217,644	-\$22,587	-\$15,945,497	-\$15,835,580	-\$10,164,390	-\$9,626,446	\$9,910,015
		-\$239,466	-\$19,777	-\$6,517,946	-\$9,185,458	-\$9,300,862	-\$9,349,996	
Medicaid Rehab became new benefit during year 11		-\$147,219	-\$22,317	-\$9,503,023	-\$9,356,037	-\$9,335,080	-\$9,759,910	
Children's outreach lead to more adults, including adults below the line (Adults-expansion) during year 11		-\$55,980	-\$4,897,321	-\$6,331,070	-\$9,099,586	-\$9,574,826	-\$9,540,739	

Appendix B

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	DY15	DY16	DY17	DY18	DY19	DY20
Mandatory State Plan Groups							
Pregnant women and infants under age 1	Up to 185 % FPL	178999	189018	166870	142035	162363	37893
Pregnant IMM/COFA		0	1954	8929	6254	7425	1612
Children 1-5	Up to 133% FPL	341362	381974	408971	417547	436854	106189
Children 6-18	Up to 100% FPL	505116	583763	635484	663951	712247	178417
Adult/Children AFDC related family members covered by	Up to 100% FPL	253126	287428	332051	354384	384203	93318
Transitional Medicaid (Section 1925) Children	Coverage is for two six-month or one four-month periods due to increased earnings or child support, respectively, make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL	29595	29465	33520	41749	47646	11718
Section 1925 Transitional Medicaid Adults	Coverage is for two six-month periods due to increased earnings, or for four months due to receipt of child support, either of which would otherwise make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL	16619	15317	19267	24563	27680	6835
Optional State Plan Groups							
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance	Up to 100% FPL	496	538	689	407	445	174
Children through the S-CHIP Medicaid expansion	101 - 200% FPL and for whom the State is claiming Title XXI funding	215957	250263	254863	269875	354509	88535
Medically Needy Adults and Children	Up to 300% FPL, if individuals otherwise eligible under State Plan groups described above spend down to Medicaid	2	7097	41552	41282	42779	10249
CHIPRA							
Children who are not eligible for CHIP	201- 300% FPL - who could be eligible through 1902 (r) (2) and for whom the State is claiming Title XIX funding. Eligibility criteria requiring prior enrollment in QUEST or						
Demonstration eligible Groups							
Adult AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid.	Up to 100% FPL (using TANF methodology)	613	259	169	229	493	45

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	DY15	DY16	DY17	DY18	DY19	DY20
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Up to 100% FPL (using GA methodology)	48602	49051	53112	55098	66839	15609
Childless adults who meet Medicaid asset limits.	Up to 100% FPL (subject to an enrollment cap presently set at 125,000)	296483	355006	422299	459140	324043	44254
QUEST Net Adults	Up to 100% FPL Eligible to enroll in QUEST but elected QUEST-Net	3115	3179	3324	3660	85663	30540
QUEST Net Adults	Up to 133% FPL but exceed QUEST asset or income	9790	9458	9372	9060	14064	5912
QUEST ACE		70038	115481	135409	149689	263023	87338
QUEST-Net-Children Demonstration Eligible Groups	FPL Level and/or other qualifying Criteria						
Children who could be eligible for SCHIP	201-300% FPL for whom the State is claiming Title XXI funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	29714	35478	42539	46312	273	65