Hawaii QUEST Expanded
Section 1115 Draft Annual Report
March 27, 2013

Demonstration Reporting Period:
Demonstration Year: 18 (7/1/2011 – 6/30/2012)

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Introduction

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

The current extension period beginning February 1, 2008 builds upon the successful QEx program for women, children and childless adults by extending comprehensive managed care to individuals who qualify for Medicaid as aged, blind or disabled (ABD).

From the very beginning of the QUEST Expanded demonstration, the goals and objectives have been centered on improving the overall health of the indigent, fiscal management, clinical access and quality of care, and provider availability. The specific objectives are to:

1. Improve health outcomes and reduce inappropriate utilization;
2. Improve the overall health of Hawaii's most vulnerable citizens under a coordinated care management environment;
3. Decrease the percentage of uninsured individuals in the State; and
4. Expand access to Home and Community Based Services (HCBS)

The current extension period is from February 1, 2008 to June 30, 2013.

Health Delivery System

The State of Hawaii's 1115(a) demonstration has two programs: QUEST and QUEST Expanded Access (QExA). The QUEST program is for children and adults who are under the age of 65 and do not have a disability. The QExA program is for adults 65 years and older and children or adults with a disability. Table 1 provides a list of enrollment by program.

Both the QUEST and QExA programs are managed care delivery systems. Enrollment into managed care is mandatory.

The QUEST program has three health plans: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. MQD enacted the commencement of services to members for the current contract of the QUEST program on August 1, 2007. This contract expired on June 30, 2012.

The Department of Human Services (DHS) reprocured this contract in August 2011. The reprocurement awarded contracts for the QUEST program to five health plans: AlohaCare, HMSA, Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. This new contract was implemented on July 1, 2012.

The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan (formerly Evercare QExA). MQD enacted the commencement of services to members for the current contract of the QExA program on February 1, 2009. This contract expires on June 30, 2011 with three one-year options to extend for the State of Hawaii. DHS has extended this contract for June 30, 2012 and June 30, 2013. DHS will extend it again one more year.

The benefits offered by QUEST and QExA are comprehensive benefit packages. See Table 2 for a list of benefits provided to both QUEST and QExA members. Table 3 contains a list of the carve-out benefits for either QUEST or QExA.

Operational/Policy Developments/Issues

During demonstration year 18, the MQD worked with the QUEST Expanded Access (QExA) health plans on implementation of the QExA program. More about QExA implementation will be included at later parts of the report.

The MQD did not have any major programmatic changes in QUEST or QExA in demonstration year 18.

The MQD performed its third year of Pay for Performance in the QUEST program. The MQD is financially incentivizing the QUEST health plans to improve quality in the following areas:

- Childhood Immunizations
- Emergency Department Visits/1000
- LDL Control in Diabetes
- Chlamydia Screening
- Getting Needed Care

The MQD uses both HEDIS and CAHPS survey results to monitor progress in these areas for the QUEST health plans. The QUEST health plans had an opportunity to receive $0.20 PMPM for improvement in each of the areas listed above for a maximum of $1.00 PMPM. Improvement is not required in all areas to receive the financial incentive.

In demonstration year 18, the health plans received financial incentives for performance improvement (see table to the right).

	AlohaCare	HMSA	Kaiser
Childhood Immunization	No	No	Yes
Clamydia Screening	No	No	Yes
LDL Control-Comprehensive Diabetes Care	No	No	Yes
Getting Needed Care- CAHPS	No	No	Yes
ED Visits/1000	Yes	Yes	Yes

Outreach/Enrollment Activities

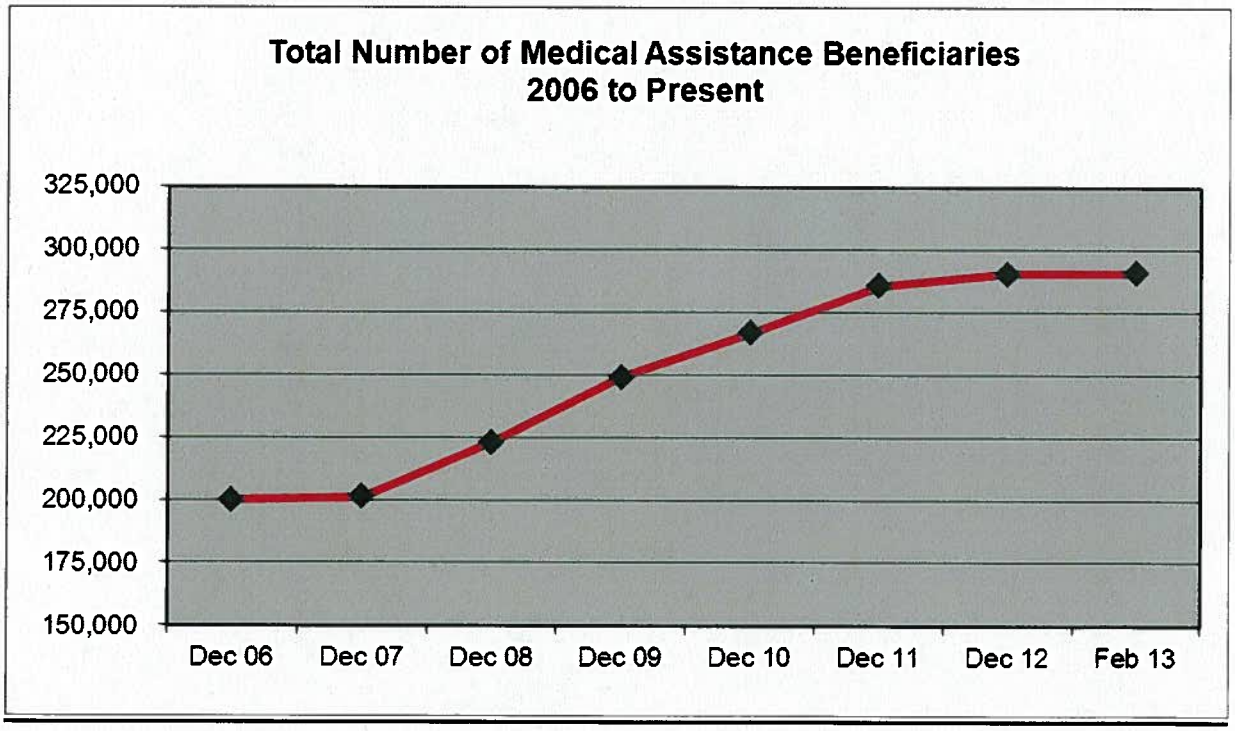
This annual report includes information on the outreach and enrollment for the Demonstration. The DHS continues to collaborate with the Federally Qualified Health Centers (FQHCs) to increase Medicaid enrollment. During SFY12, the Department received 9,275 medical applications from the FQHCs. The number of medical applications has decreased by approximately 20% the since SFY11 when approximately 11,617 medical applications were submitted.

In both SFY10 and SFY11, the FQHCs submitted approximately 11,600 applications per year (11,541 and 11,617, respectively). In SFY 08 and SFY09, MQD received a significantly lower number of applications from the FQHCs (7,142 and 7,803, respectively). The decrease in SFY12 may be seen as a return to more consistent levels of applications being submitted by the FQHCs.

The DHS has a contract with the Hawai'i Primary Care Association for outreach and enrollment. This contract is responsible for outreach to families to enroll both children and pregnant women into Medicaid. Outreach primarily occurs through the FQHCs.

The Demonstration had a five (5) percent increase in enrollment over State Fiscal Year 2010. The majority of this enrollment occurred in the QUEST program. See Table 1 for enrollment statistics.

The MQD has had an increase in enrollment of 36% since December 2006. See chart below for visual of the increase in enrollment of the Demonstration program in Hawaii.



Outcomes, Quality and Access to Care

MQD Quality 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 Quality Strategy is posted at the MQD website (www.med-quest.us).

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. A copy of the list of the QUEST and QExA programs' reported HEDIS 2012 measures, including the validated HEDIS 2012 measures, is attached in Attachment A. Below is more detailed information regarding HEDIS.

In November 2012, the MQD released a Consumer Guide for the QUEST and QExA programs that compared several of their HEDIS measures as well as results from the Adult CAHPS survey in the spring of 2012. The consumer guides are posted on the MQD website. The MQD will continue to compile this data for public reporting in the future. See Attachment B for a copy of the 2012 QUEST and QExA Consumer Guide.

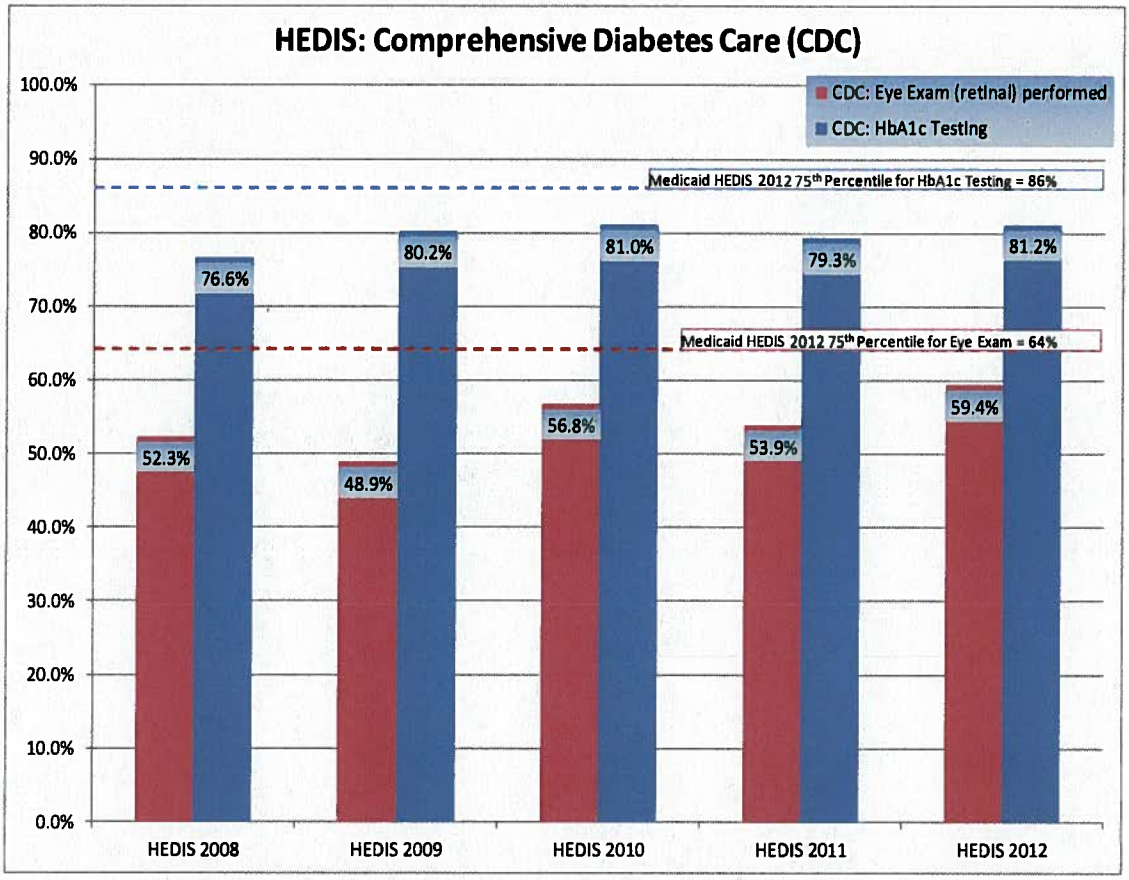
The MQD performed an Adult CAHPS survey in the spring of 2012. Members of both the QUEST and QExA health plans were provided an opportunity to participate in this survey. See Attachment C for a copy of the QUEST and QExA CAHPS Star Report of the following points of information: Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors' Communicate, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Below is more detailed information regarding the CAHPS survey.

QUEST & QExA HEDIS 2012

The most recent reported HEDIS year for QUEST & QExA is HEDIS 2012. The six EQRO audited scores for this year for the QUEST plans were Childhood Immunization Status (CIS), Well-Child Visits in the First 15 Months of Life (W15), Controlling High Blood Pressure (CBP), Comprehensive Diabetes Care (CDC), Ambulatory Care (AMB) and Chlamydia Screening in Women (CHL). The six measures reviewed for the QExA plans were Cholesterol Management for Patients with Cardiovascular Conditions (CMC), Comprehensive Diabetes Care (CDC), Adults' Access to Preventive/Ambulatory Health Services (AAP), Ambulatory Care (AMB), Inpatient Utilization – General Hospital/Acute Care (IPU), Plan All-Cause Re-Admissions (PCR)

Below is a description of the Hawaii Composite Score (weighted average score based on the individual health plan scores):

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 59% from 2008 to 2012, 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 five years reported. The latest year (2012) 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 – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2012 -- the latest year with a national averages -- this target was 64%, which was better than all of the years reported.

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 81% from 2008 to 2012, with the highest rate of 81.2% occurring in 2012 and the lowest rate of 76.6% occurring in 2008.

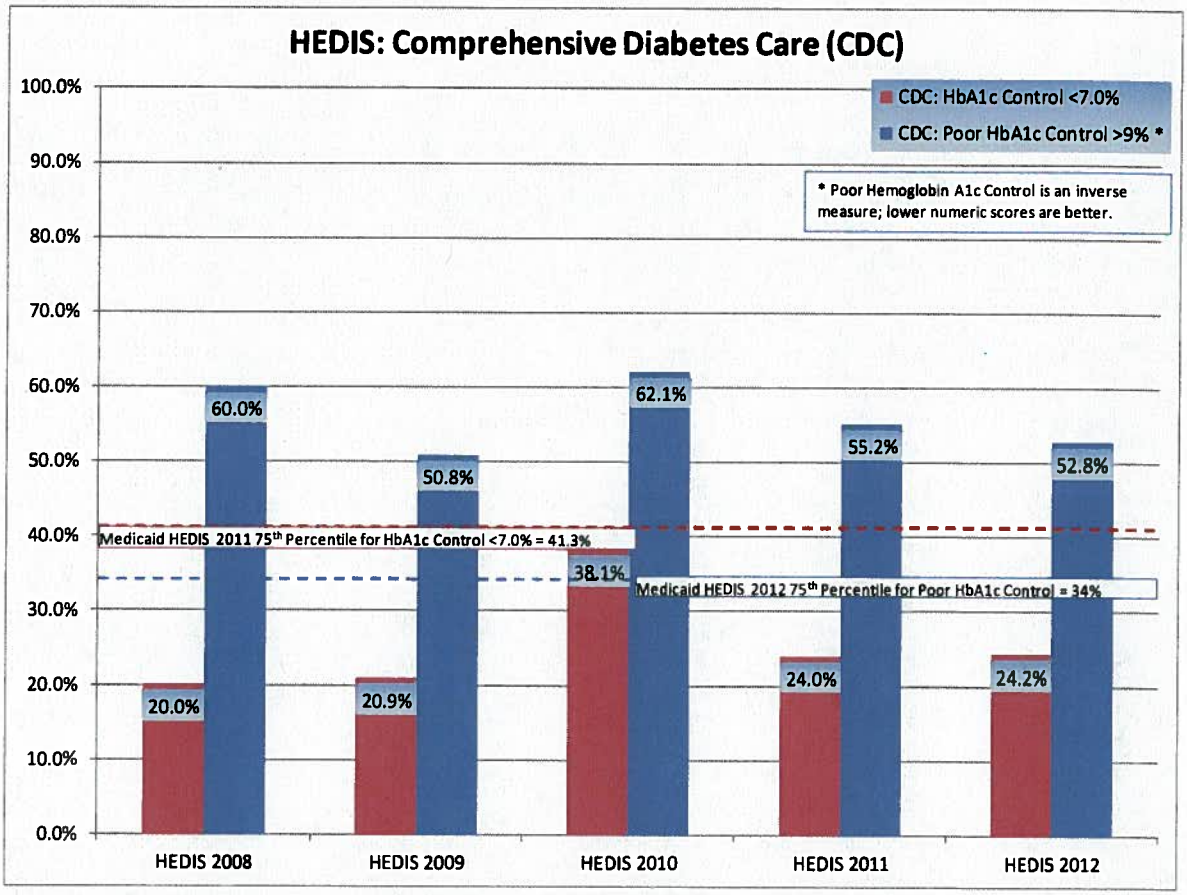
- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the lowest rate was reported in 2008.

- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2012 -- the latest year with national averages -- this target was 86%, which 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 38% from 2008 to 2012, 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 five years reported. The latest year (2012) reported the highest rate, and the earliest year (2008) reported the lowest rate. There is what seems like an outlier score in 2010 of 38.1%, especially when considering the four other years' scores were bunched between 20.0% and 24.2%



  - 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 2011 -- the national averages -- this target was 41.3%, which is above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

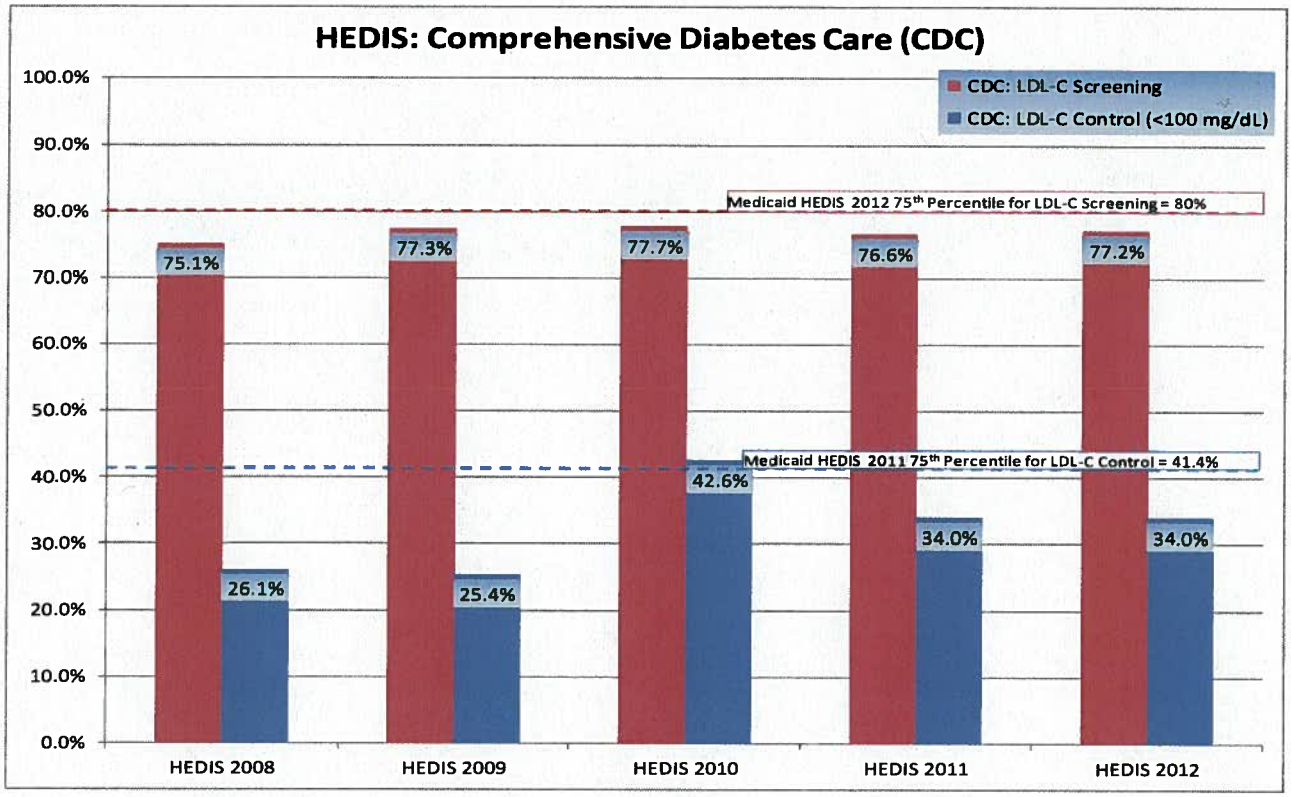
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 62% and 50% from 2008 to 2012, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 50.8% occurring in 2009. Note that this 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 five years reported. The last three years' score went from 62.1% to 55.2% to 52.8%, yet the lowest score occurred in 2009 (50.8%).

  - The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 75th percentile of the national Medicaid population. For the 2012 this target was 34%, 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 2012, 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 five 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 2012 -- the latest year with national averages -- this target was 80%, which is slightly higher than all of the previous year reported.

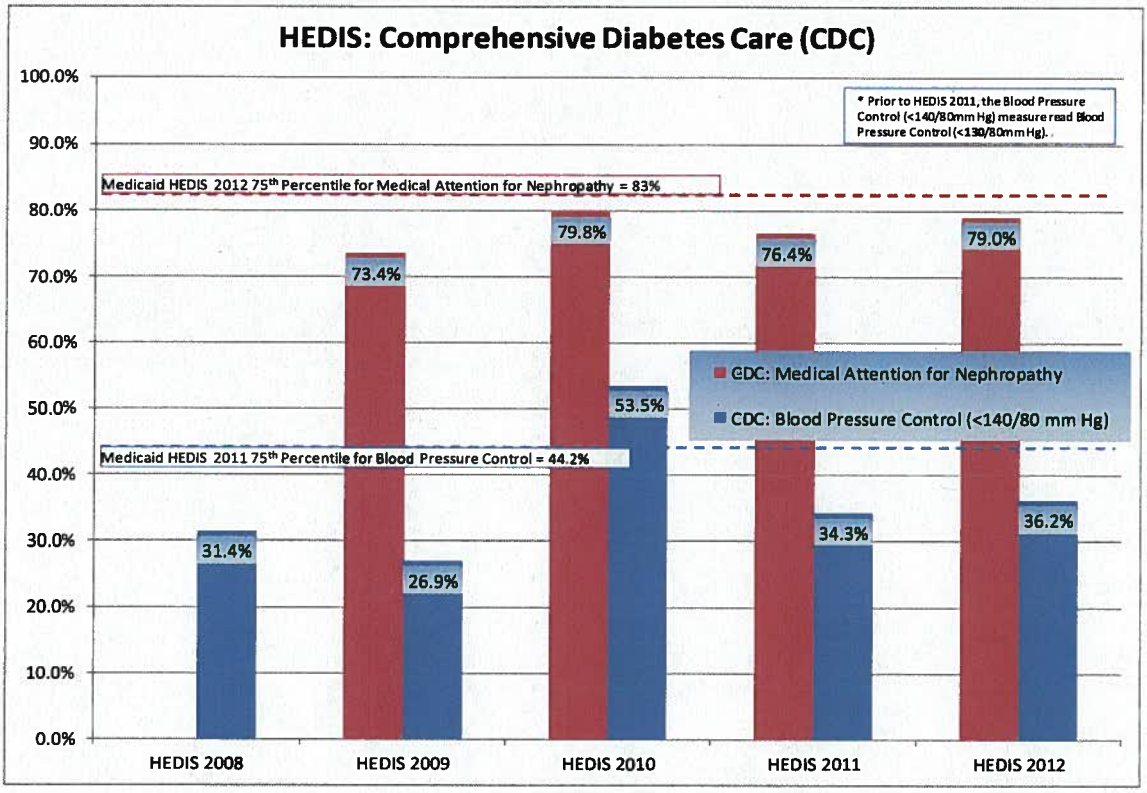
CDC – LDL-C Control:

- 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 2012, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- There is no change from the score in 2011 at 34.0%. The HI Quality Strategy target percentage for the CDC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the national averages -- this target was 41.4%, which is higher than the rates reported in 2011 and 2012.

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



2012, 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.

- The HI Quality Strategy target percentage for the CDC –Medical Attention for Nephropathy is the 75th percentile of the national Medicaid population. For the 2012 this target was 83%, which is higher than all of the years reported.

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

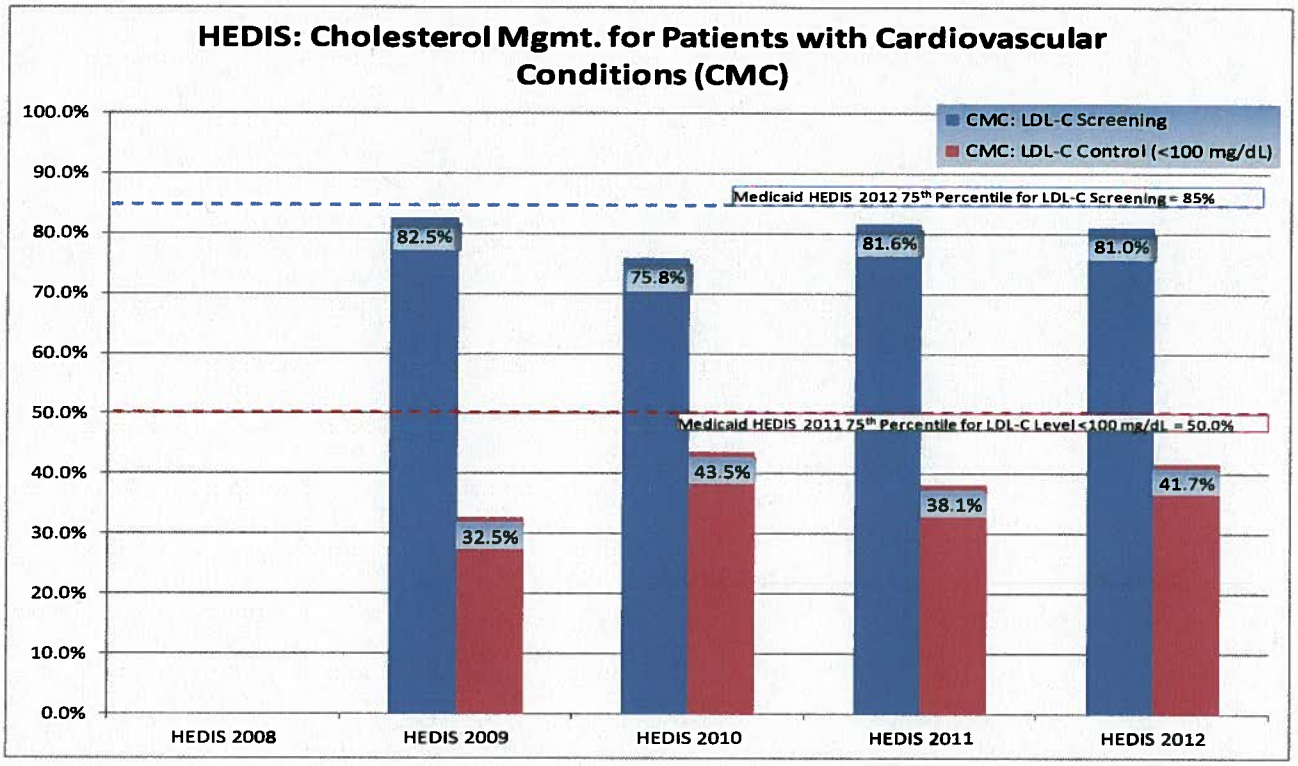
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2012, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2011 (34.3%) and 2012 (36.2%).

- The HI Quality Strategy target percentage for the CDC- Blood Pressure Control (140/80mm Hg)measure is the 75th percentile of the national Medicaid population. For the 2011 -- the national averages -- this target was 44.2%, which 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 82% from 2009 to 2012, with the highest rate of 82.5% occurring in 2009 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 year (2009), 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 2012 -- the national averages -- this target was 85%, which is higher than all of the years reported.

CMC – LDL-C Control:

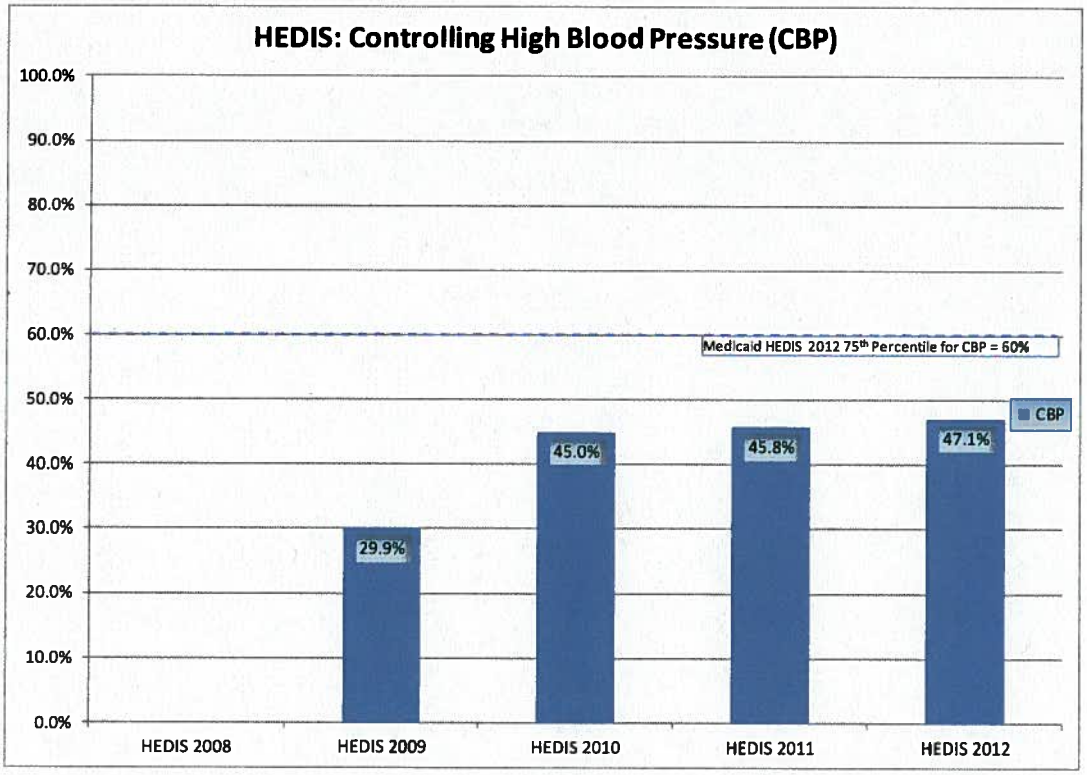
- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 43% from 2009 to 2012, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010, the highest two scores were in 2011 (38.1%) and 2012 (41.7%).

- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the national averages target was 50.0%, which is higher than all of the years reported.

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 47% from 2009 to 2012, with the highest rate of 47.1% occurring in 2012 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.

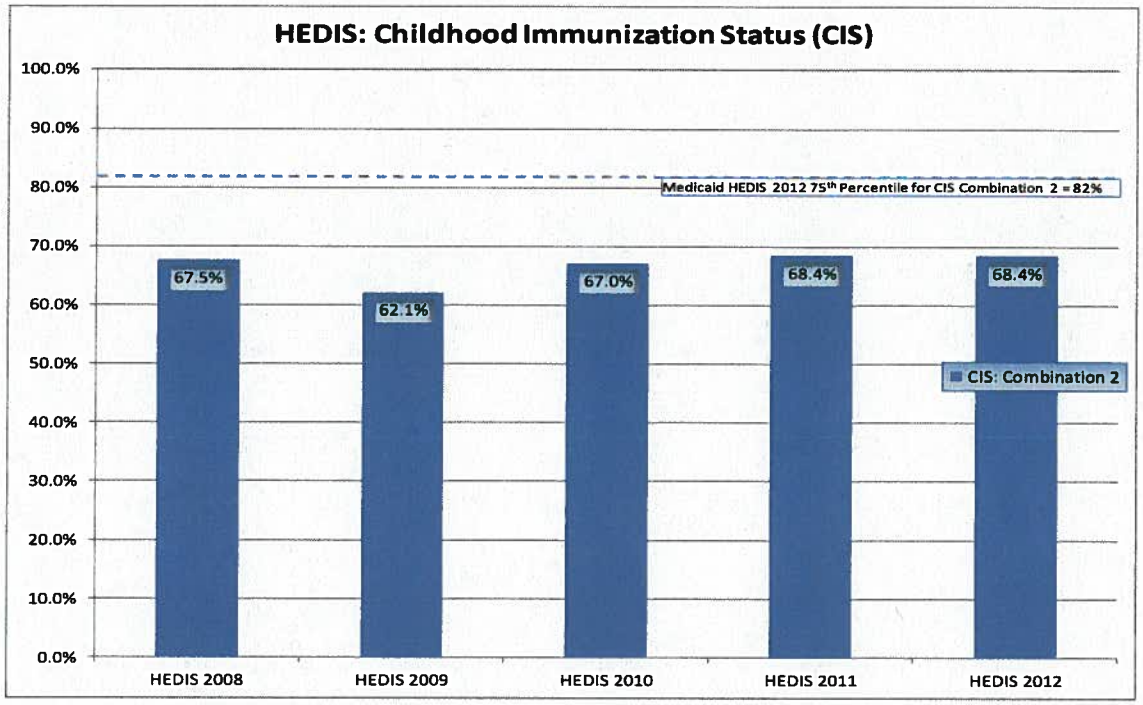


- There is a clear up trend in the rates of the five years reported. From 2009 thru 2012, each subsequent year's score is higher than the last.

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2102 – the latest year with national averages -- this target was 60%, which 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 69% from 2008 to 2012, with the highest rate of 68.4% occurring in 2011 & 2012 and the lowest rate of 62.1% occurring in 2009.

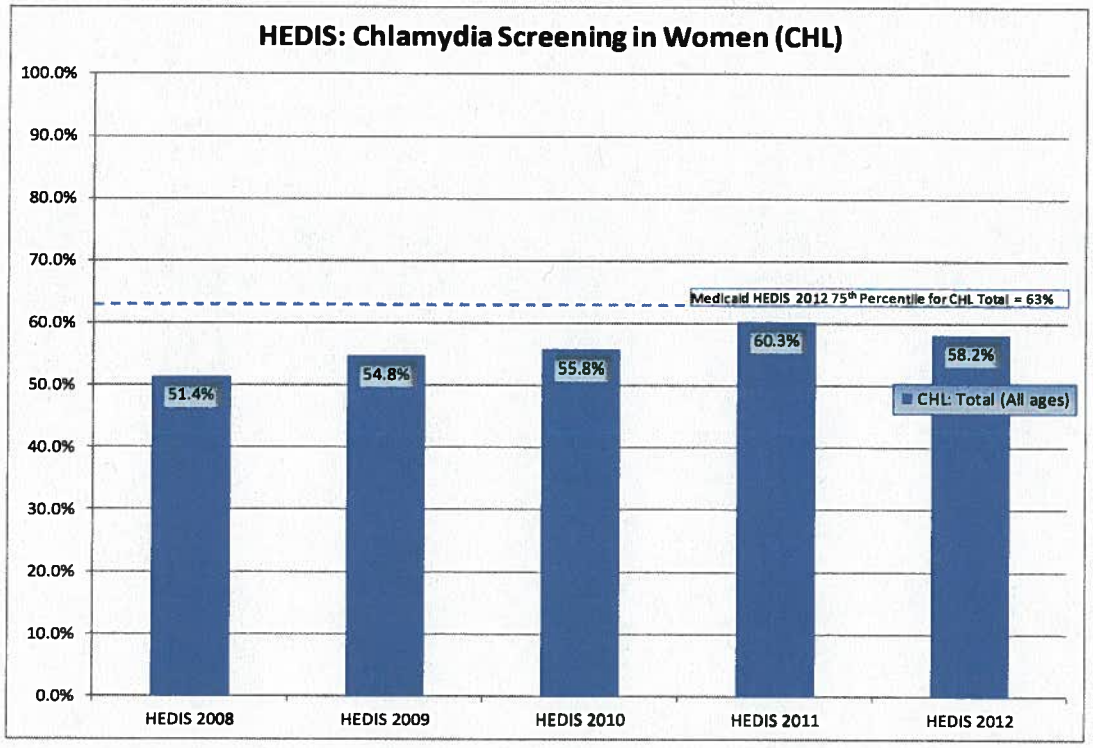


- There is a slight up trend in the rates of the five years reported. Excluding the 2008 rate, the rates increased from 2009 to 2012 by 4.1 percentage points with not yearly decreases.

- The HI Quality Strategy target percentage for the CIS (Combination 2) measure is the 75th percentile of the national Medicaid population. For the 2012 -- the latest year with national averages -- this target was 82%, which 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 60% from 2008 to 2012, with the highest rate of 60.3% occurring in 2011 and the lowest rate of 51.4% occurring in 2008.

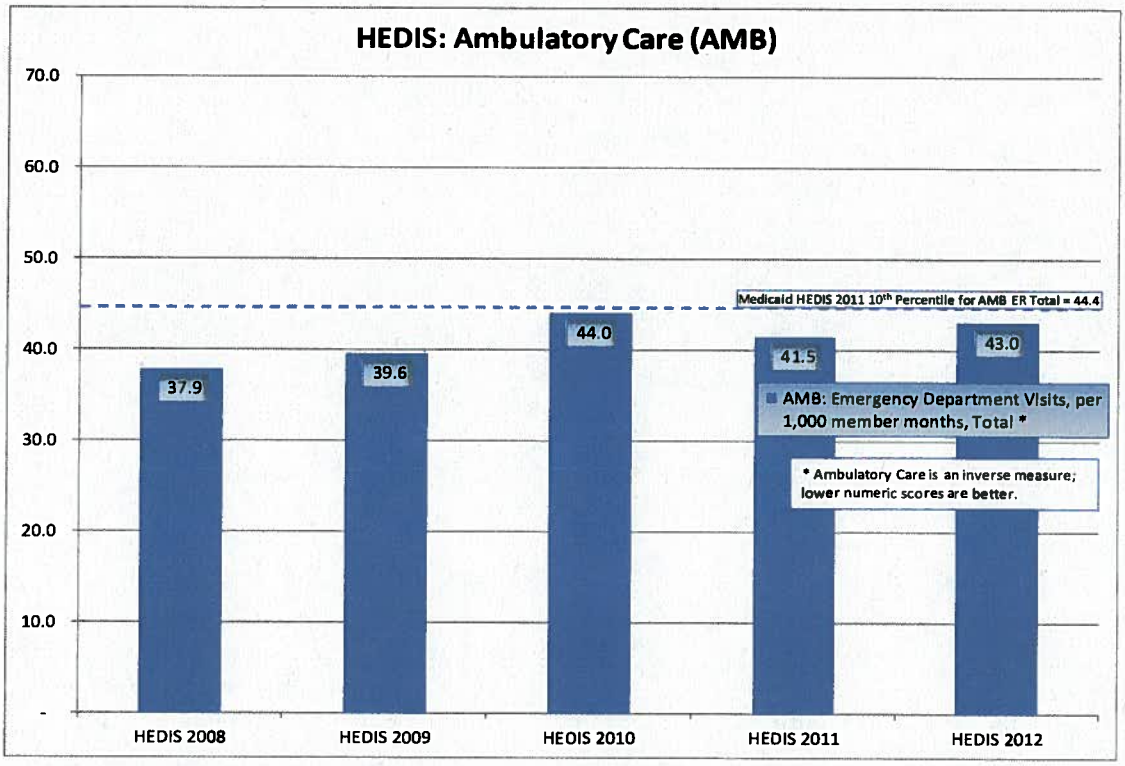


- There is a clear up trend in the rates of the five years reported. Removing the most recent score, the lowest rate (51.4%) is in 2008 and the highest rate (60.3%) is in 2011.

- The HI Quality Strategy target percentage for the CHL measure is the 75th percentile of the national Medicaid population. For the 2012 -- the latest year with national averages -- this target was 63%.

AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.9 and 44.0 from 2008 to 2012, 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.

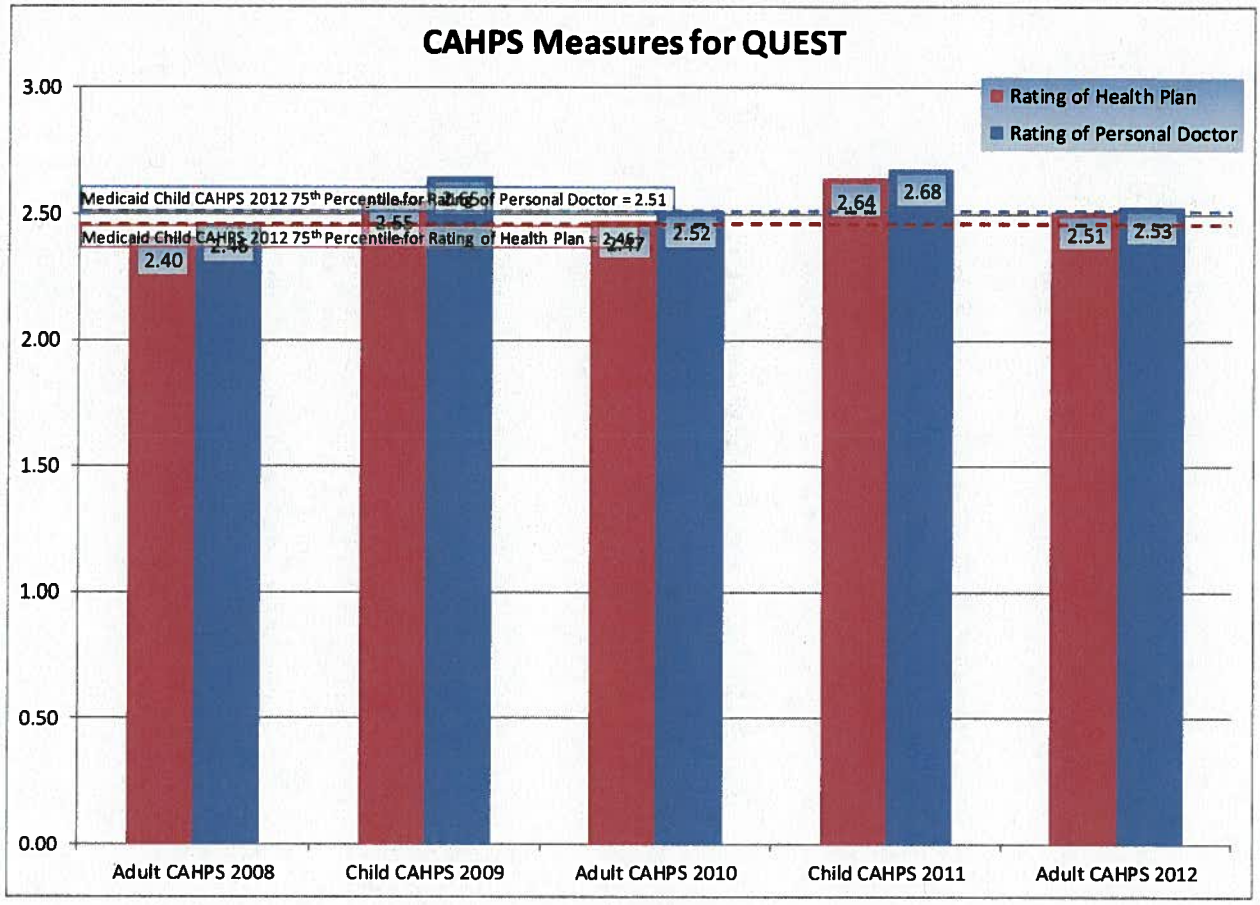


- There is a clear up trend (bad) in the rates of the five years reported. Putting aside the high rate in 2010, the lowest rate (37.9) occurred in 2008, and the highest rate (43.0) occurred in 2012.

- The HI Quality Strategy target percentage for the AMB measure is the 10th percentile of the national Medicaid population. For the 2011 -- the national averages -- this target was 44.4, which is higher (good) than all of the years reported.

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 five years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show a similar pattern, moving from 2.55 to 2.64.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.46, which was exceeded by the 2.51 rate reported in 2012.

CAHPS for QUEST – Rating of Personal Doctor:

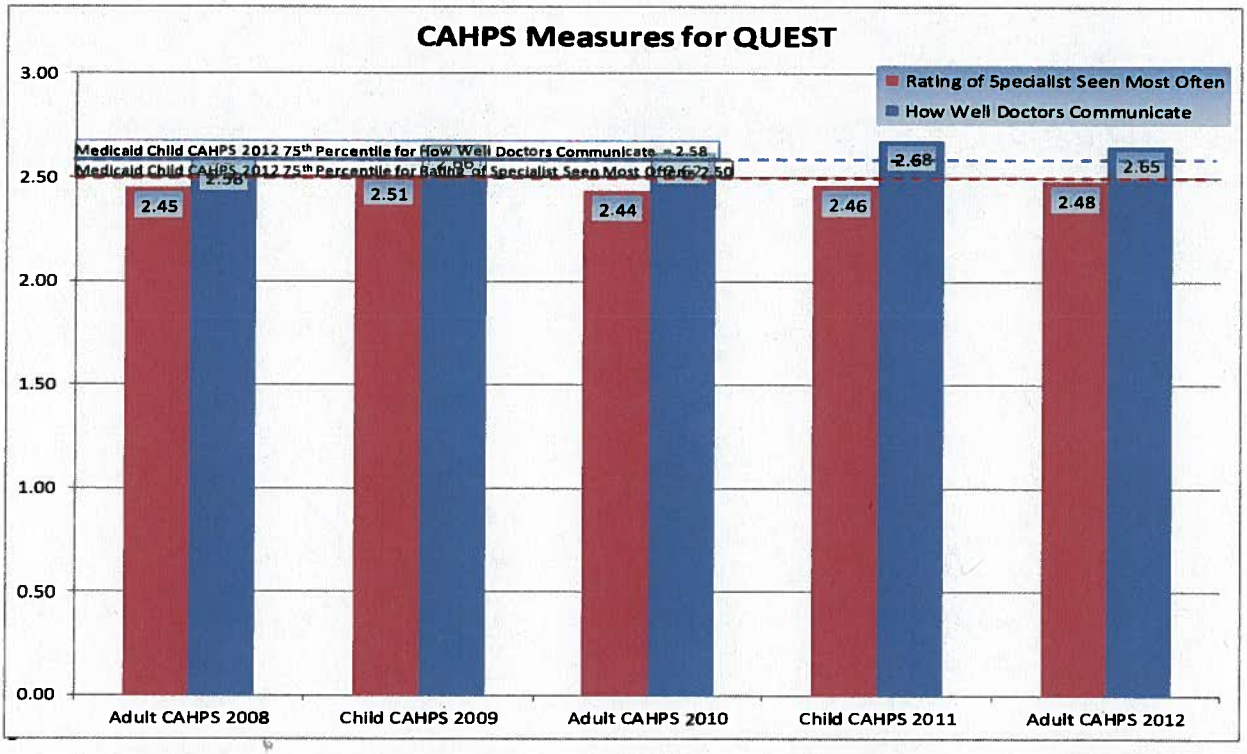
- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a similar pattern, moving from 2.65 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.51, which was exceeded by the 2.53 rate reported in 2012.

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.

- 

end in the rates of the five 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.

- 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 2012 year -- the latest year with national averages -- this target was 2.50, which was higher than the rate reported in 2012.

- 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 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 five 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.

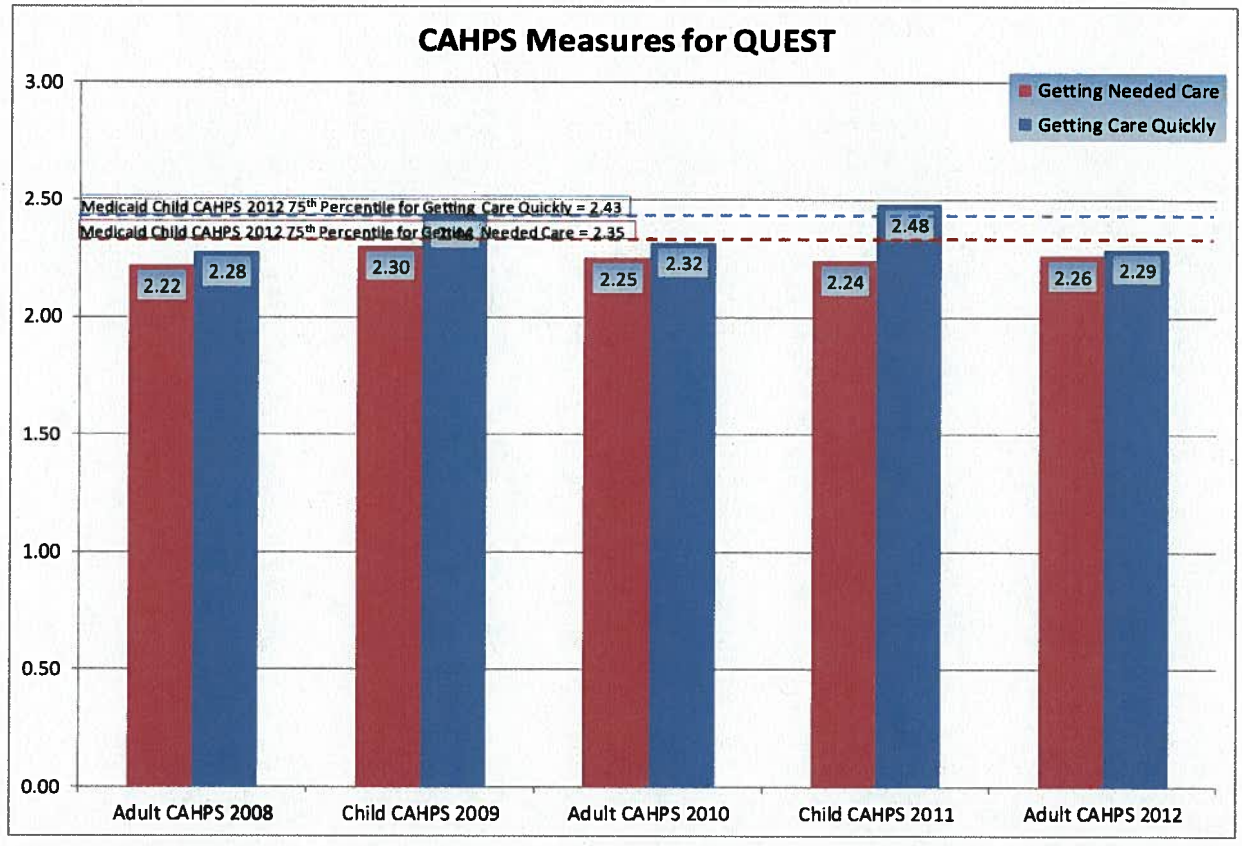
- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.58, which was exceeded by the 2012 rate of 2.65.

- 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 2.30 occurring in 2009 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 five 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, moving from 2.30 to 2.24.



- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.35, which was higher than all of the reported year.

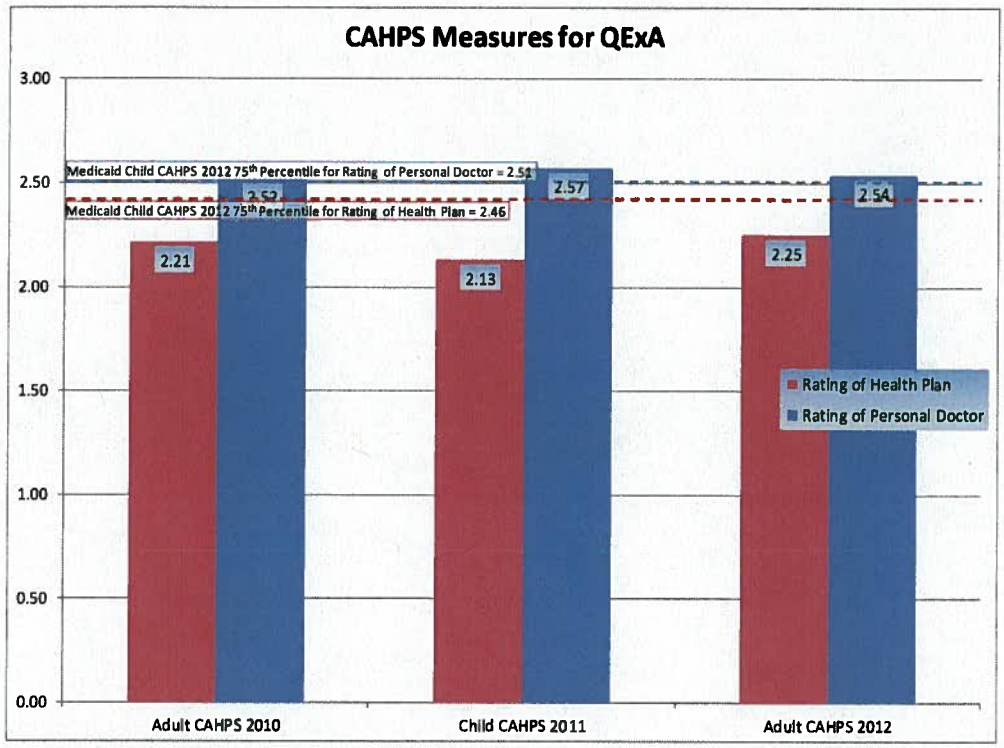
CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.48 occurring in 2011 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 five 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.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.43, which was higher than the reported year 2012.

CAHPS for QExA – Rating of Health Plan:



- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.25 occurring in 2012 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 three years reported. The low point in 2011 was the only data point for the Child population.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2012 year this target was 2.46, which was better than all reported rates.

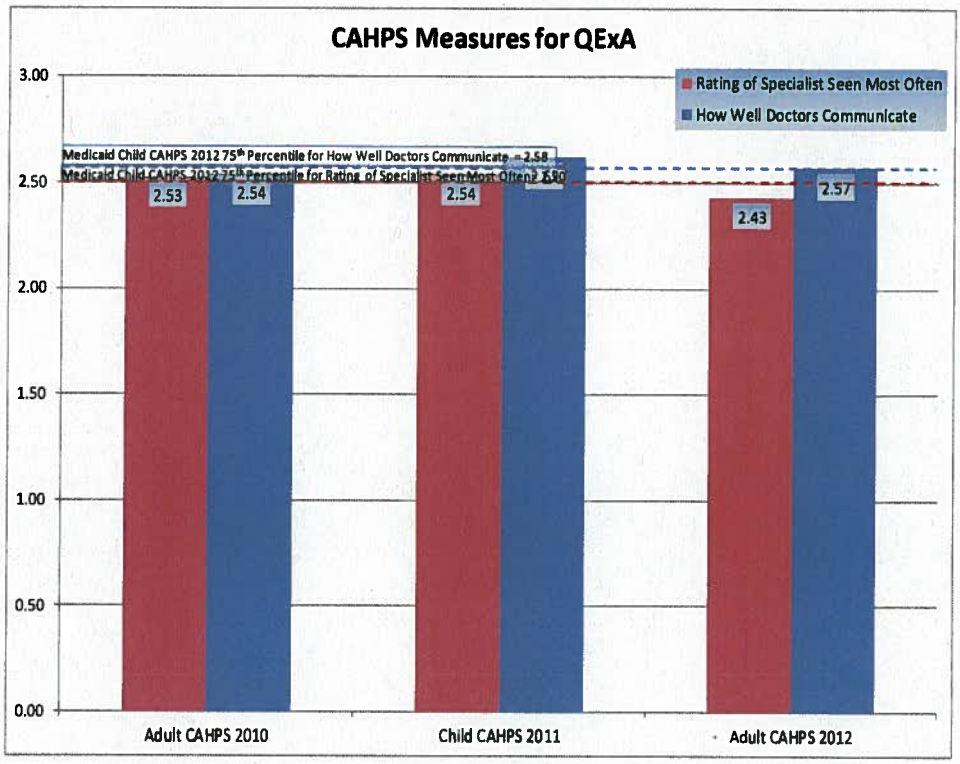
CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.57 occurring in 2011 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 three years reported. All years lie within a 0.05 point window.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.51, which was exceeded by all reported rates.

CAHPS for QExA – Rating of Specialist Seen Most Often:



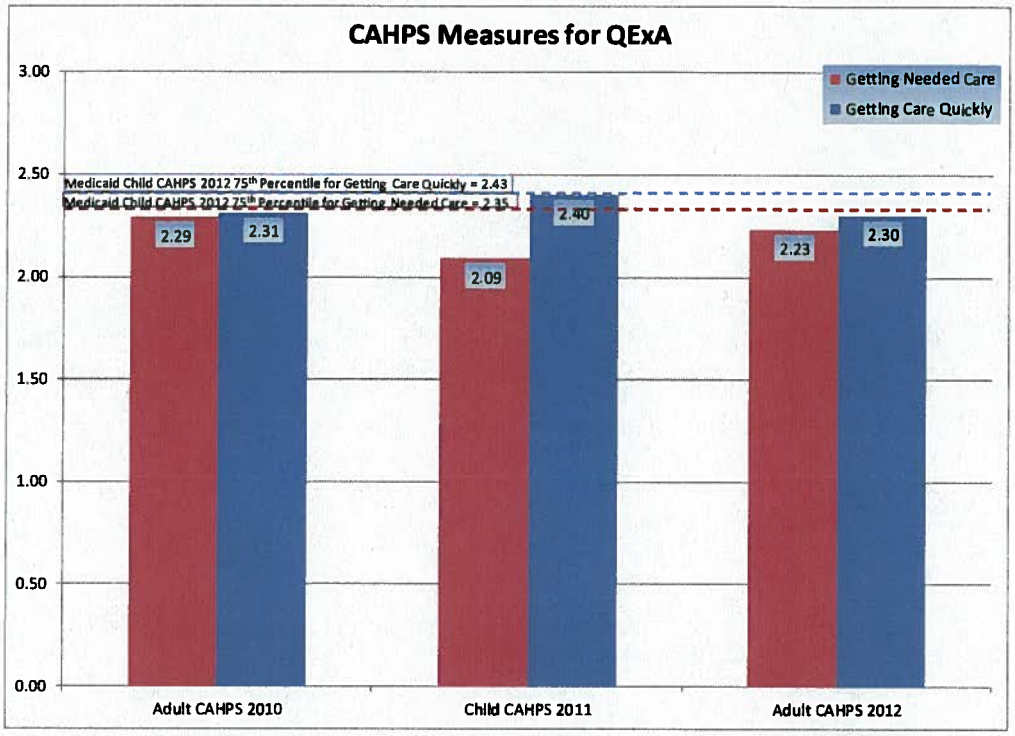
- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.54 occurring in 2011 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.
  - There is no clear trend in the rates of the three years reported.
- 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 2012 year -- the latest year with national averages -- this target was 2.50, which was higher than reported year 2012.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.62 occurring in 2011 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no trend in the rates of the three years reported. Removing the Child year in 2011, the Adult score moves from 2.54 to 2.57 from 2010 to 2012.
- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- the target was 2.58 and was slightly higher than in reported year 2012.

CAHPS for QExA – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QExA population varied between a high rate of 2.29 occurring in 2010 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 rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.35, which was 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 2.40 occurring in 2011 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2012 year -- the latest year with national averages -- this target was 2.43, which was higher than all of the reported years.

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.

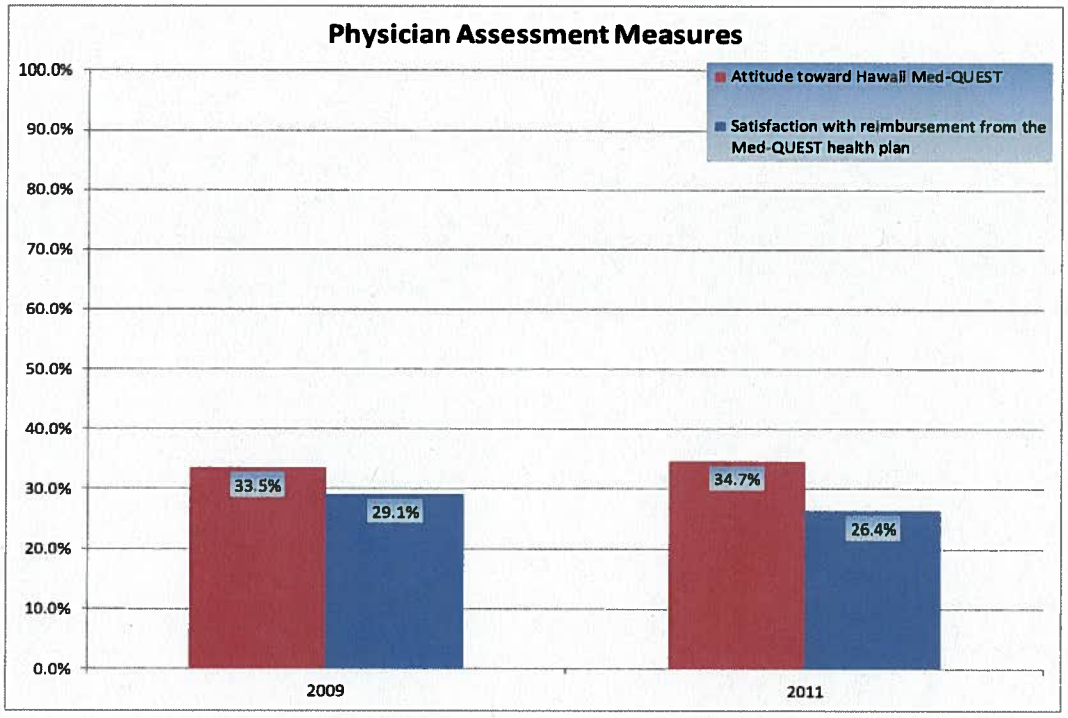
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall survey response rate was 30% in 2009 and 26% in 2011. Going forward, these surveys will not be done every 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 and 2011. 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.



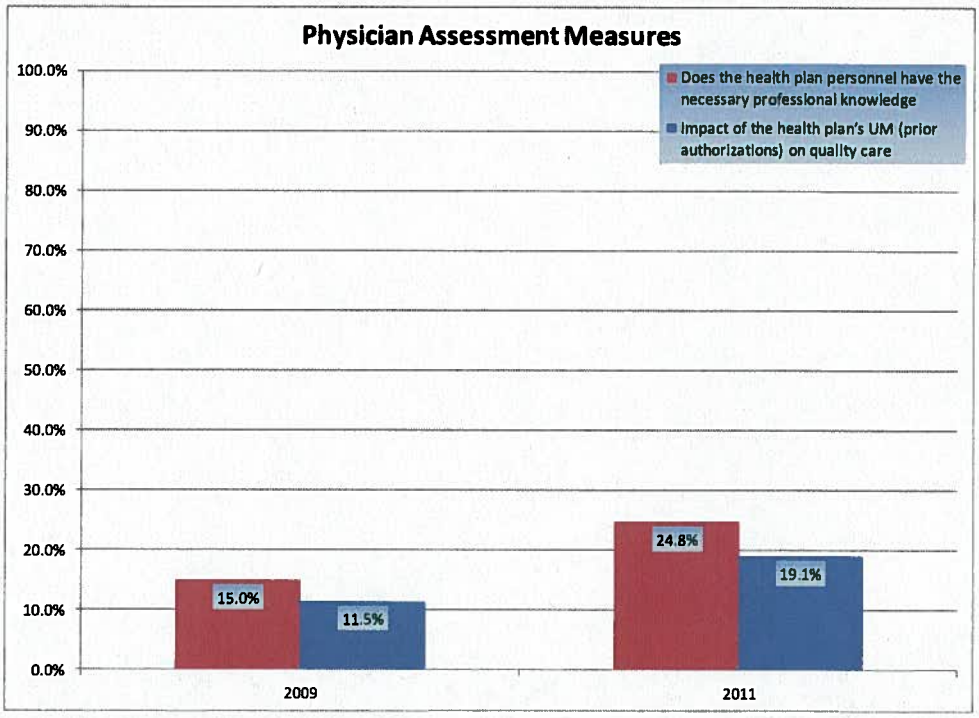
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

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.
- 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.

Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% 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.



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.
- 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.

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

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.
- 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.
- 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 diabetic. This toolkit included an educational brochure and diabetes checklist for members to use in managing their diabetes.
- Distributing periodic newsletters with diabetes articles and updates.

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.

- 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.

- Established patient reminder and recall systems that include: 1) Postcard reminders, and 2) Telephone to non-responders for missed appointments and/or immunizations.

    - One 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 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 plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.

- Implemented mechanisms to collect and report the data in a supplemental database so that immunizations that are provided without a claim being submitted to the plan can still be tracked and reported.

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 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 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.

CAHPS (QUEST & QExA) Initiatives

Rating of Health Plan & Rating of Personal Doctor Initiatives:

- Utilized online and technology assets to outreach to members.

    - One plan launched a new Health & Wellness section on its website, along with notifying member of this new section.

- One 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 plan conducted member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.
  - One 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 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 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 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 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 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 plan streamlined the provider search functionality on their website.
  - One plan increased the update frequency of the online provider directories to daily.

- One plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.

- One 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 plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.

  - One plan conducted ongoing member surveys to further gauge timely access to care.

- Personally assisted members with obtaining needed provider appointments.

  - One 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 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 plan merged systems that track gaps in HEDIS-related care with customer service, so that during member calls the customer service rep can reminder the member that they need to see a provider and even offer to set up an appointment.

  - One 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 QUEST plans simplified the drug prior authorization process by standardizing the form across all QUEST plans.

  - One plan made physician biography cards available at clinic locations to facilitate physician comparisons and selection.

  - One plan allocated $300,000 over the past four years to support recruitment and retention of providers, particularly on the neighbor islands.

  - One plan implemented a 24-hour nurse triage call line equipped with specialty trained nurses and an audio health library.

  - One plan added the ability of QUEST members to email the plan's QUEST department directly from the health plan website.

- One 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.

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 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 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 plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
  - One plan increased staff coaching and mentoring activities.
  - One plan conducted monthly knowledge quizzes to gauge whether additional training is needed.
- Initiated improvements to the prior authorization process.
  - One plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
  - One plan added an online PA application to streamline the PA process.
  - One plan increased provider training and education related to the online PA process.
  - One plan distributed handouts on the PA process during periodic provider relations visits.
  - One 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 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 plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

Other Quality Projects

MQD continues to work on strategies and measures related to home and community based services, which will affect mostly our QExA health plans, the Developmental Disability and Intellectual Disability (DD/ID) program, and the Going Home Plus (GHP) program. MQD started implementing CMS' Quality Framework for Home and Community Based Services (HCBS) in SFY2012. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority.

MQD developed behavioral health monitoring tools to measure the transition and on-going implementation of providing behavioral health services for Hawaii's Medicaid SMI population. Some of the areas measured include:

- Services provided
- Health plans meeting case management acuity (i.e., assuring that case managers are meeting with their clients in accordance with timeframes established during a psychosocial assessment)
- Acute psychiatric hospitalizations
- Discharge planning and follow-up with seven days after an acute psychiatric hospitalization
- Management of sentinel events

Measures for inpatient care and long-term care will need to be developed in the future in partnership with our stakeholders. Measures for the QUEST and QExA populations will vary.

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

Quality Activities during the demonstration year

The State of Hawaii, Med-QUEST Division has a contract with Health Services Advisory Group (HSAG) to perform its EQRO activities. In 2012, MQD moved into the third of its three year cycle for mandatory external quality review that is described in Code of Federal Regulations (CFR) at 42 CFR 438.358. For this review, the HSAG performed a desk review of documents and an on-site follow up review of the re-evaluation of health plan compliance that included reviewing additional documents and conducting interviews with key staff members from each health plan. HSAG evaluated the degree to which each health plan complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to the access and measurement and improvement standards in 42 CFR 438.214-230, Subpart D. The five standards included requirements that addressed the following areas:

- Delegation

- Member Information
- Grievance System
- Provider Selection
- Credentialing

Each health plans was provided a report that described their areas of success as well as areas for improvement. Corrective Action Plans (CAP) was required for areas requiring improvement. Across all five plans the grievance system had the highest number of CAPs. HSAG provided technical assistance to the health plans on April 16, 2012 to clarify the difference between member and provider grievances and appeals and to gain better understanding of the differences between provider and member complaints, grievances and appeals.

HSAG performed Performance/HEDIS validation reports as well as PIP reports. In regards to the PIPs, in 2012, MQD informed the health plans that there will be a new PIP scoring methodology that will place greater emphasis on PIP outcomes. The validation reports reveal that the health plans were good in the design and implementation stage but there was improvement needed in the area of outcomes. A variety of suggested activities was provided to the health plans which included conducting causal barrier analysis and improving PIP documentation. Other EQRO activities include the completion of the CAHPS Adult survey with the finalization of reports.

In addition, the EQRO completed the Annual Technical Report, which includes follow-up and updates from the previous year's Technical report submitted from the health plans. The Annual Technical Report is posted on the MQD website. We also continue to do inter-rater reliability reviews with our PRO level of care determinations.

We are continuing to actively working on strategies and measures related to home and community based services. These include establishing guidelines and reporting requirements as well as oversight of grievance and appeals processes, nursing assessments, among others. We have met with the health plans to do an overview, and we will follow-up with regular meetings with the health plans specifically for the implementation of HCBS monitoring.

Most importantly, we are establishing and implementing an internal quality flow processes that will guide all quality activities from reporting to analysis to corrective action to system changes. We are establishing Quality Committees and Leadership Teams according to the Quality Strategy.

Improvement of Health Plan Report Forms and Monitoring Tools

In demonstration year 18, MQD continues to align the report forms and monitoring tools for these programs wherever possible. MQD is developing tools for health plan reporting and review tools for MQD staff to use to standardize report analysis. This process is ongoing and will continue into demonstration year19. Prior to any health plan report tool being issued, MQD receives input from the QUEST and QExA health plans. MQD implemented nine templates this demonstration year.

Cost of Care

Financial Performance of the Demonstration

The Demonstration expended approximately $1.6 billion to provide services to Medicaid clients in Hawaii (both State and Federal funds). See Attachment D for summary of financial expenditures for demonstration year 18.

The adjustments to the state fiscal biennium 2013-2014 budgets were completed with the passage of the Supplemental Budget bill in May 2012.

Financial/Budget Neutrality Development/Issues

The MQD submitted budget neutrality for each quarter in demonstration year 18.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	July to September 2011 (1st qtr)	October to December 2011 (2nd qtr)	January to March 2012 (3rd qtr)	April to June 2012 (4th qtr)
Aged	58,408	60,326	59,732	60,626
Blind/Disabled	71,962	73,167	73,026	73,057
Children (EG1)	389,496	399,743	404,247	404,998
Adults (EG2)	267,671	279,884	283,587	283,101
HCBS				

B. For Informational Purposes Only

With Waiver Eligibility Group	July to September 2011 (1st qtr)	October to December 2011 (2nd qtr)	January to March 2012 (3rd qtr)	April to June 2012 (4th qtr)
MQD Plan Adults	103,824	105,470	108,308	106,942
MQD Plan Children	303,091	306,862	311,655	312,077
Optional MQD Plan Children				
Optional MQD Plan Children MCHP	75,865	82,515	82,152	82,671
CHIPRA	10,418	10,287	10,367	10,154
Foster Care Children	122	79	73	96
Medically Needy Adults				
Demonstration Eligible Adults (QUEST & QUEST-Net Adults)	128,394	135,511	135,713	136,164
Demonstration Eligible Adults (QUEST-ACE)	35,453	38,903	39,556	39,995
UCC – Governmental				
UCC – Private				

With Waiver Eligibility Group	July to September 2011 (1st qtr)	October to December 2011 (2nd qtr)	January to March 2012 (3rd qtr)	April to June 2012 (4th qtr)
NHWW	N/A	N/A	N/A	N/A
RAACP	N/A	N/A	N/A	N/A
MFCCP	N/A	N/A	N/A	N/A
HCCP	N/A	N/A	N/A	N/A
Aged with Medicare	54,749	55,743	55,848	56,398
Aged without Medicare	3,659	4,583	3,884	4,228
Blind/Disabled with Medicare	28,815	29,250	29,271	29,482
Blind/Disabled without Medicare	43,059	43,816	43,649	43,472

QUEST Expanded Consumer Issues

The MQD has two areas that address consumer issues. The MQD Customer Service Branch and the Health Care Services Branch, Quality and Member Relations Improvement Section (HCSB/QMRI). Both of these areas addressed consumer issues for the QUEST, QExA and Fee-For-Service (FFS) programs. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (either QUEST or QExA), they transfer those telephone calls to the HCSB. The clerical staff person(s) takes the basic contact information and assigns the call to one of the social workers. MQD tracks the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., into a QExA health plan), then the CSB will work with the client to resolve their issue. Below are charts for QUEST, QExA, and the FFS program for DY 18.

QUEST Consumer Issues

During the demonstration year 18, the HCSB/QMRI, as well as other MQD staff, processed approximately 33 member and provider telephone calls and e-mails (see table to below) for the QUEST program.

	Member/Provider
3rd qtr 2011	12
4th qtr 2011	10
1st qtr 2012	8
2nd qtr 2012	3
Total	33

These numbers are not distinct members or provider, but are distinct issues. The number of calls from members and providers is higher in SFY12 than in SFY11. Through implementation of the QExA program, HCSB/MPRS has formalized processes to address consumer issues. The processes have been formally communicated to the public through the QExA program, but not yet for the QUEST program. This communication shall occur during SFY2013. HCSB/QMRI anticipates having a larger number of consumers contact us regarding the QUEST program.

QExA Consumer Issues

During the demonstration year 18, the HCSB/QMRI staff, as well as other MQD staff, processed approximately 181 member and provider telephone calls and e-mails (see table to right). These numbers are not distinct members or providers, but are distinct issues. The number of calls from members is approximately 25% less than from the start of QExA when the HCSB received approximately 73 member calls in the first quarter of 2009.

	Member	Provider
3rd qtr 2011	27	15
4th qtr 2011	36	23
1st qtr 2012	30	11
2nd qtr 2012	30	9
Total	123	58

The number of provider calls decreases every month. HCSB staff received 82 provider calls in the first quarter of 2009- January to March 2009.

The MQD and the QExA health plans continue to have two regularly scheduled meetings. One of the meetings is a monthly meeting with the Case Management Agencies. The meetings with these agencies are focused around continually improving and modifying processes within the health plans related to HCBS. In addition, a QExA transition group formed on the island of Maui. This group meets bi-monthly to address Maui specific issues regarding QExA. The members of this group are mostly other State agencies as well as a few provider groups (i.e., one of the FQHCs on Maui) and a few QExA consumers. The primary issue being addressed at this time is growing the health plans provider networks on Maui.

Most of the communication with providers occurs via telephone and e-mail at this time. The MQD will

arrange any meetings with QUEST or QExA health plans and provider groups that are requested.

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

The MQD continued its QExA Ombudsman program with the organization Hilopa'a Family to Family Health Information Center (F2FHIC). This organization, run by Leolinda Parlin, is a HRSA funded information center for families of children with special health care needs. "Veteran moms" staff the center. The center provides guidance and assistance to parents and caregivers in navigating the medical and non-medical support systems available for their children. As such, this organization is uniquely suited to providing this important service to our QExA enrollees.

The number of calls in the QExA Ombudsman program has increased over the demonstration year (see table to right). The starting month of the program, the Ombudsman received 662 calls; the Ombudsman received 197 calls per month (on average) during the second year of the program (see Attachment E for Third Year Ombudsman program report). A year later, the average number of calls per month is approximately 67 calls. The Four Year of the QExA Ombudsman report is attached as Attachment F.

Calls to QExA Ombudsman Program		
	# of calls	Distinct Callers
3rd qtr 2011	164	125
4th qtr 2011	215	151
1st qtr 2012	194	164
2nd qtr 2012	235	184
Total- average	202	156

Approximately 30% of the calls are from the Neighbor Islands (rural portion of Hawaii). This is consistent with the QExA population demographics of approximately 68.5% living on Oahu and 31.5% living on the Neighbor Islands. Therefore, the Ombudsman program represents the QExA population statewide.

The QExA Ombudsman describes the types of calls as those requesting a better understanding of how to navigate within the QExA program.

FFS Consumer Issues

During the demonstration year 18, the HCSB/MPRS, as well as other MQD staff, processed approximately 75 member and provider telephone calls and e-mails (see table to below). These numbers are not distinct members or provider, but are distinct issues. As noted, this number continues to increase each quarter. Through implementation of the QExA program, HCSB has formalized processes to address consumer issues. The processes have been formally communicated to the public through the QExA program, but not yet for the FFS program. In addition, though the FFS program is small, HCSB continues to receive calls from both FFS members and providers.

	Member/Provider
3rd qtr 2011	15
4th qtr 2011	16
1st qtr 2012	23
2nd qtr 2012	21
Total	75

Appeals

During the demonstration year 18, the HCSB processed 44 appeals (see table to below). All of these appeals were appealing the health plans decision to reduce or deny services. In these appeals, MQD

sided with the client or the hearing officer felt that the actions taken by the health plan were not appropriate (i.e., the appeal was overturned) in 2 of the 44 appeals (4.5%). The hearing officer felt that the actions taken by the health plan were appropriate (i.e., the appeal was upheld) in 13 of the 44 appeals (29.6%). Two (2) clients did not show for their hearing, so these appeals were upheld. In addition, seven (7) of the appeals were withdrawn and twenty-two (22) of the appeals were dismissed. Administrative resolution was approximately 65.9% of the appeals.

	Appeals
3rd qtr 2011	19
4th qtr 2011	4
1st qtr 2012	14
2nd qtr 2012	7
Total	44

Audits and Lawsuits

Audits

The MQD undergoes an audit annually that includes managed care programs. The audit was held in January 2013. No deficiencies in managed care areas were found in this audit.

Lawsuits

At this time, there are no other legal actions that affect the demonstration.

Demonstration Programmatic Areas specific to QUEST Expanded Demonstration

Benchmarks for QUEST-ACE

From documented inquiries, the MQD received only a few calls about QUEST-ACE all related to limited medical and drug coverage. Based on QUEST-ACE enrollment of 14,995 at the end of demonstration year 18, DHS is reporting no complaints and no trends to address.

QExA Transition

The MQD monitored QExA implementation to assure that the health plans were effectively transitioning MQD clients from the FFS program into managed care. The MQD utilized staff in the Health Care Services Branch (HCSB) to address client and provider issues.

The MQD met with the health plans monthly. Monthly meetings discuss all pertinent issues related to post- QExA implementation. The QExA Ombudsman continued to be included in the monthly health plan meetings. Topics for discussion included, but were not limited to:

- provider concerns;
- reporting requirements;
- items identified from MQD oversight; and
- program clarifications.

Reporting

The MQD receives reports consistent with the reporting requirement in the QExA RFP. MQD staff review quarterly and annual reports for compliance with the QExA program.

The QAIS nurses continued to perform in-home assessments for any clients for whom the health plans or MQD were concerned about their transition to managed care. After completed, the MQD would discuss the assessment results in detail with the health plans to assure appropriate services were provided.

The MQD receives a monthly report called the QExA Dashboard. The MQD uses the Dashboard to share information on the QExA program with the public. The Dashboard contains information on member and provider demographics, call center statistics, claims processing, complaints from both members and providers, and utilization data. The 2011 compilation of the QExA Dashboard is attached as Attachment G and the June 2012 version of the QExA Dashboard is attached as Attachment H.

The number of member calls for demonstration year 18 is consistent. 'Ohana continues to receive more member calls on average than United. United had a spike in member calls in January 2012. On average, over demonstration year 18, United received approximately 3,909 and 'Ohana received approximately 4,086 member calls per month (see table to the right). This is a decrease from the first year of QExA implementation. When Evercare was receiving approximately 5,665 and 'Ohana was receiving approximately 6,854 member calls per month.

# of member calls received		
Monthly	'Ohana	United
Start of QExA	5,665	6,854
3rd qtr 2011	4,317	3,601
4th qtr 2011	3,388	3,947
1st qtr 2012	3,982	4,222
2nd qtr 2012	4,655	3,865
Total- av	**4,086**	**3,909**

The primary types of calls the health plans are receiving relate to pharmacy benefit, eligibility information, and ID card requests.

Evercare has less provider calls than 'Ohana in demonstration year 18. Evercare has seen an increase in the number of provider calls since January 2011. 'Ohana has maintained approximately that same number of provider calls over demonstration year 18 as well as at the start of the program. MQD continues to monitor these statistics closely due to the concern that providers having access to the health plan helps in resolution of problems.

# of provider calls received		
Monthly	'Ohana	United
Start of QExA	3,711	6,666
3rd qtr 2011	4,166	3,929
4th qtr 2011	4,045	3,481
1st qtr 2012	4,192	3,827
2nd qtr 2012	3,951	3,442
Total- av	**4,089**	**3,670**

QExA Enrollment

Call Center Statistics

The MQD contract is the QExA Enrollment Call Center (QECC) to ACS. The QECC handled 20,749 calls during demonstration year 18. MQD ended its contract with the QECC on June 30, 2012. These services were transitioned to the MQD's Enrollment Call Center (ECC) effective July 1, 2012.

Calls Answered by the QECC	
3rd qtr 2011	4,570
4th qtr 2011	6,188
1st qtr 2012	5,862
2nd qtr 2012	4,129
Total- DY18	20,749

Annual Plan Change

QExA Annual Plan Change (APC) was in November 2012 to coordinate with new MIPAA requirements. This information will be communicated in future CMS reports

Field Counselors

The QECC field counselors remained at one field counselor during demonstration year 18. This employee meets with clients or providers as needed to communicate information about the QExA program.

Home and Community Based Services (HCBS) Waiting List

The QExA health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

MQD monitors the number of clients receiving HCBS when long-term care services were required. The number of clients requiring long-term care services continues to rise. In the second quarter of 2012, the increase has risen by 42.4% since the start of the program. HCBS has absorbed all of this increase instead of nursing facility services. Nursing facility services have decreased by approximately 12.8% since program inception.

	2/1/09	2nd Qtr 2012, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 2nd Qtr 2012
HCBS	2,110	4,572	116.7%↑	42.6%	64.9%↑
NF	2,840	2,476	12.8%↓	57.4%	35.1%↓
Total	4,950	7,048	42.4%↑		

The number of clients receiving HCBS has increased by approximately 116.7%. At the start of the program clients receiving HCBS was 42.6% of all clients receiving long-term care services. This number has increased to almost 65% (64.9%) since the start of the program.

Status of the Demonstration Evaluation

MQD submitted its interim demonstration evaluation to CMS on September 5, 2012, during Demonstration Year 19.

MQD Contact(s)

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Tables

Table 1- Enrollment Counts

	June 2011	June 2012	Percent Change
By Program			
QUEST			
1925- Transitional Medicaid	5,183	6,361	22.7%
Adult/Children AFDC Family members covered by Section 1931	83,146	85,674	3.0%
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	5,327	5,208	(2.2%)
General Assistance	5,176	5,292	2.2%
Immigrant Children Moved into a QUEST program with implementation of CHIPRA	0	0	
QUEST-Net	1,144	1,015	(11.3%)
QUEST	68,908	74,354	7.9%
QUEST-ACE	12,395	13,845	11.7%
S-CHIP	25,141	27,340	8.8%
TANF	14,084	15,129	7.4%
QUEST Total	**225,301**	**234,218**	**4.0%**
QUEST Expanded Access (QExA)			
Aged, Blind, Disabled (ABD)	41,069	42,665	3.9%
QExA Spenddown	2,365	2,375	0.4%
Other (QMB, SLMB, QDWI)	3,483	3,781	8.6%
QExA and other ABD Total	46,917	48,821	4.1%
BHH (Basic Health Hawaii)	25	18	(28.0%)
QUEST State Funded	4,772	4,845	1.5%
QUEST/QExA/Other Total	**272,218**	**287,902**	**5.8%**
Health Plan			
AlohaCare	76,302	81,752	7.1%
HMSA	119,944	126,292	5.3%
Kaiser	27,229	27,968	2.7%
QUEST FFS Window	1,826	3,069	68.1%
QUEST Total	**225,301**	**239,081**	**6.1%**
'Ohana Health Plan	23,140	23,858	3.1%
Evercare	20,204	21,109	4.5%
QExA Total	**43,344**	**44,967**	**3.7%**
Island			
Oahu	167,319	177,258	5.9%
Kauai	15,753	16,337	3.7%
Hawaii	57,182	60,925	6.6%
Maui	28,318	29,473	4.1%
Molokai	2,957	3,213	8.7%
Lanai	689	696	1.0%
Total	**272,218**	**287,902**	**5.8%**

Table 2- Benefits for QUEST and QExA

	QUEST	QUEST-ACE/Net	QExA
Primary and Acute Care Services			
Cognitive rehabilitation services			X
Cornea transplants and bone graft services	X		X
Durable medical equipment and medical supplies	X		X
Emergency and Post Stabilization services	X	X	X
Family planning services	X	X	X
Home health services	X		X
Hospice services	X (60 days per benefit year)		X
Inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care	X	10 days per benefit year (no maternity or newborn care)	X
Maternity services	X		X
Medical services related to dental needs	X		X
Other practitioner services;	X	As part of 12 outpatient visits per benefit year	X
Outpatient hospital services	X	3 per benefit year	X
Personal assistance services - Level I			X
Physician services	X	As part of 12 outpatient visits per benefit year	X
Prescription drugs	X	Antibiotics only	X
Preventive services	X		X
Radiology/laboratory/other diagnostic services	X	As part of 12 outpatient visits per benefit year	X
Rehabilitation services	X		X
Smoking Cessation	X		X
Sterilizations and hysterectomies	X		X
Transportation services	X	Emergency only	X
Urgent care services	X	As part of 12 outpatient visits per benefit year	X
Vision and hearing services	X		X

	QUEST	QUEST-ACE/Net	QExA
Behavioral Health- All members			
Inpatient psychiatric hospitalizations	X	10 days per benefit year	X
Ambulatory mental health services and crisis management	X		X
Medications and medication management	X		X
Psychiatric or psychological evaluation and treatment	X	6 outpatient visits per benefit year. Able to use 6 additional outpatient visits per benefit year, if needed.	X
Medically necessary alcohol and chemical dependency services	X		X
Methadone management services	X		X
Behavioral Health- For members with diagnosis of Serious and Persistent Mental Illness			
Intensive Care Coordination/Case Management	X		
Partial hospitalization or intensive outpatient hospitalization	X		
Psychosocial Rehabilitation	X		
Therapeutic Living Supports	X		

	QUEST	QUEST-ACE/Net	QExA
Long-Term Care Services			
Home and Community Based Services			
Adult day care			X
Adult day health			X
Assisted living services			X
Attendant care			X
Community Care Management Agency (CCMA) services			X
Community Care Foster Family Home (CCFFH) services			X
Counseling and training			X
Environmental accessibility adaptations			X
Home delivered meals			X
Home maintenance			X
Medically fragile day care			X
Moving assistance			X
Non-medical transportation;			X
Personal assistance services – Level I and Level II			X
Personal Emergency Response Systems (PERS)			X
Private duty nursing			X
Residential care			X
Respite care			X
Specialized medical equipment and supplies			X
Institutional Services:			
Nursing Facility services	X (60 days per benefit year)		X

Table 3- Carve-Out programs

The programs listed below are provided outside of either the QUEST or QExA programs. If a program is not checked, it is either provided within the program or not offered at all due to eligibility criteria in QUEST and QExA.

	QUEST	QExA
Adult Mental Health Division	Within QUEST	X
Child and Adolescent Mental Health Division	X	X
Community Care Services (Behavioral Health program administered by DHS)	Within QUEST	X
Dental Services	X	X
Developmental Disabilities 1915(c) waiver		X
School Based Services	X	X
State of Hawaii Organ Transplant Program (SHOTT)	X	X
Vaccines for Children	X	X
Zero to Three (Early Intervention)	X	X