Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: September 16, 2014

Demonstration/Quarter Reporting Period:
Demonstration Year: 20 (7/1/2013 – 6/30/2014)
Federal Fiscal Quarter: 3/2014 (4/1/2014-6/30/2014)
State Fiscal Quarter: 4/2014 (4/1/2014-6/30/2014)
Calendar Year: 2/2014 (4/1/2014-6/30/2014)

Introduction

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

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

The State's goals in the demonstration are to:

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

Enrollment Information

Note: Enrollment counts include both person counts (unduplicated members) and member months. Member months and unduplicated members data for April 2014 to June 2014.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 4/2014-6/2014	Unduplicated Members 4/2014-6/2014
Mandatory State Plan Groups			
State Plan Children	State Plan Children	343,241	116,548
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	166,216	58,467
Aged	Aged w/Medicare Aged w/o Medicare	68,387	23,983
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	74,844	25,474
Expansion State Adults	Expansion State Adults	98,896	36,732
Newly Eligible Adults	Newly Eligible Adults	136,376	46,600
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	727	268
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults	95	81
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group	378	285
Total		889,160	308,438

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	308,357
Title XXI funded State Plan	34,037
Title XIX funded Expansion	81
Enrollment current as of	6/30/2014

Outreach/Innovative Activities

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

line at its mybenefits.hawaii.gov website.

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

Operational/Policy Developments/Issues

During the third quarter of FFY14, the Med-QUEST Division (MQD) continued its oversight of the QUEST program for five health plans: AlohaCare, Health Services Medical Association (HMSA), Kaiser Foundation Health Plan, 'Ohana Health Plan, and United Healthcare Community Plan. The QUEST program serves approximately 256,000 beneficiaries who are not aged or disabled

The MQD transitioned individuals with serious mental illness (SMI) from the QUEST program into the behavioral health program called the Community Care Services (CCS). MQD transitioned approximately 1,600 Medicaid beneficiaries receiving their behavioral health service from QUEST to the CCS program on April 1, 2014.

The MQD awarded contracts for the QUEST Integration or QI program in January 2014. The five health plans awarded a contract for QI are: AlohaCare, Health Services Medical Association (HMSA), Kaiser Foundation Health Plan, 'Ohana Health Plan, and United Healthcare Community Plan.

QUEST Integration or QI is a melding of both the QUEST and QExA programs. QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition.

In QUEST Integration, health plans will provide a full-range of comprehensive benefits including long-term services and supports. MQD has lowered its ratios for service coordination. In addition, MQD started provision of some home and community based services to "at risk" individuals to prevent decline in health status effective January 1, 2014.

The MQD continued to work with the QExA health plans on implementation of the QExA program.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for third quarter of FFY14 was submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (April 2014)	Month 2 (May 2014)	Month 3 (June 2014)	Total for Quarter Ending 6/2014
EG 1-Children	117,525	114,011	112,432	343,968
EG 2-Adults	59,618	53,992	52,801	166,311
EG 3-Aged	22,494	23,196	22,697	68,387
EG 4-	24,618	25,289	24,937	74,844

Blind/Disabled				
EG 5-VIII-Like Adults	222	124	32	378
EG 6-VIII Group Combined	79,357	78,577	77,338	235,272

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (April 2014)	Month 2 (May 2014)	Month 3 (June 2014)	Total for Quarter Ending 6/2014
State Plan Children	117,295	113,764	112,182	343,241
State Plan Adults	59,471	53,947	52,798	166,216
Aged	22,494	23,196	22,697	68,387
Blind or Disabled	24,618	25,289	24,937	74,844
Expansion State Adults	31,338	33,139	34,419	98,896
Newly Eligible Adults	48,019	45,438	42,919	136,376
Optional State Plan Children				
Foster Care Children, 19-20 years old	230	247	250	727
Medically Needy Adults				
Demonstration Eligible Adults	47	45	3	95
Demonstration Eligible Children				
VIII-Like Group	222	124	32	378

QUEST Integration Consumer Issues

The MQD Customer Service Branch (CSB) received no concerns this quarter regarding the QUEST or QExA programs. The Health Care Services Branch, Quality and Member Relations Improvement Section (HCSB/QMRIS) received no calls regarding the QUEST program during the third quarter of FFY14.

	Member			Provider		
	QUEST	QExA	FFS	QUEST	QExA	FFS
April 2014	2	11	0	1	3	3
May 2014	3	15	5	1	5	7
June 2014	0	6	1	0	2	6
Total	5	32	6	2	10	16

MQD's FFS program received six (6) calls from beneficiaries and sixteen (16) calls from providers. The HCSB/QMRIS addressed all of these calls.

HCSB Grievance

During the third quarter of FFY14, the HCSB continued to handle incoming calls. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (either QUEST or QExA), transfer those telephone calls to the HCSB. The clerical staff person(s) takes

the basic contact information and assigns the call to one of the social workers. MQD tracks all of the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., into a QExA health plan), then the CSB will work with the client to resolve their issue. The CSB did not have any calls related to QExA this quarter.

During the third quarter of FFY14, the HCSB staff, as well as other MQD staff, processed approximately 49 member and provider telephone calls and e-mails (see table above). The number of calls from members is consistent with other quarters. In previous quarters, MQD received approximately 59 calls, letters, and e-mails.

HCSB Appeals

The HCSB received eleven (11) appeals in the third quarter of FFY14. Of the eleven (11) appeals that we received, DHS was able to dismiss seven (7) of them by working with the health plan to cover the requested service. The other four (4) appeals went to hearing and the hearing officer found that the health plan had correctly processed three (3) of the denials. One (1) of the denials was processed as incorrect by the health plan. The types of appeals were primarily LTSS (8) with two (2) medical and one for transportation.

Types of Appeals	#
Medical	2
LTSS	8
Other: Transportation	1

Category	#
Submitted	11
DHS resolved with health plan in member's favor prior to going to hearing	7
Hearings	
Resolution in DHS favor	3
Resolution in Member's favor	1

Provider Interaction

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

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

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

Enrollment of individuals

The DHS had a reduction of enrollment of approximately 7,000 members during the third quarter of FFY14. Of this group, 45 chose their health plan when they became eligible, 3,741 changed their health plan after being auto-assigned.

	#
Individuals who chose a health	45

In addition, DHS had 182 plan-to-plan changes during the third quarter of FFY14. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 10 individuals in the QUEST Expanded Access (QExA) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

plan when they became eligible	
Individuals who changed their health plan after being auto-assigned	3,741
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	182
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	10

Long-Term Services and Supports (LTSS)

HCBS Waiting List

During the third quarter of FFY14, the QExA health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the third quarter of FFY14, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of clients requiring long-term services and supports continues to increase. In the third quarter of FFY14, the increase is 46.4% since the start of the program receiving long-term services and supports. The number of individuals in nursing facilities decreased this past quarter. HCBS usage has more than doubled since the start of the QExA program. Nursing facility services have decreased by approximately 10.3% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 123% since program inception. 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 65% (64.9%) since the start of the program.

	2/1/09	2nd Qtr FFY14, av	3rd Qtr FFY14, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 3rd Qtr FFY14
HCBS	2,110	4,824	4,699	123%↑	42.6%	64.9%↑
NF	2,840	2,571	2,546	10.3%↓	57.4%	35.1%↓
Total	4,950	7,395	7,245	46.4%↑		

Behavioral Health Programs Administered by the DOH and DHS

The DHS transferred approximately 1,500 individuals from the QUEST program into the Community Care Services (CCS) program on April 1, 2014. Individuals in CCS have a Serious Mental Illness (SMI) diagnosis with functional impairment. The Medicaid beneficiaries who continue to receive services from AMHD are legally encumbered. These individuals are under court order to be cared for by AMHD.

Program	#
Adult Mental Health Division (AMHD/DOH)	261
Child and Adolescent Mental Health Division (CAMHD/DOH)	3,300
Community Care Services (CCS/DHS)	6,025

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). CAMHD is providing services to approximately 3,300 children during the third quarter to FFY14.

QUEST Integration transition

The DHS started QUEST Integration transition or readiness review for QUEST Integration health plans on February 1, 2014. Readiness review during the third quarter of FFY14 consisted of submission of documents to MQD for review and MQD's review of those documents. MQD developed a process for tracking, review and return of submissions. In addition, MQD developed review tools for assuring that all deliverables meet contract requirements.

During this quarter, MQD performed three trainings for health plans. Trainings were:

- Putting QI into EPSDT
- Why It's Not Good Enough to Be Patient & Family Centered… Honoring Diversity
- Leading the Way to Make Sure Your Consumer Directed Program is on the Right Path

During this quarter, MQD developed of standardized health and functional assessment and service plan tools. These tools were issued to health plans the end of the third quarter of FFY 14. In addition, MQD developed templates for meeting Federal regulations for the Grievance system.

MQD started planning for its on-site health plan reviews that will be conducted in the fourth quarter of FFY14. MQD issued health plan an agenda and copies of the review templates for their preparation.

Quality Assurance/Monitoring Activity

MQD Quality Strategy

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

We are continuing to work on strategies and measures related to home and community based services, which will affect mostly our QExA health plans, the DDID program, and the Going Home Plus program. MQD submitted a quality grid for monitoring the DDID program to CMS with the recent waiver amendment, and we have been working to implement this. The quality grid included measures

that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also been working on behavioral health monitoring and quality improvement. Measures on 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.

MQD is in the process of updating its quality strategy for the QUEST Integration program.

Quality Activities during the quarter
The following is a description of the EQRO activities completed for this quarter. EQRO performs oversight of health plans for the QUEST, QUEST Expanded Access (QExA) and Community Care Services (CCS) programs:

1. PIPS – MQD is requiring the QUEST Plans to have the same PIP topics of 1) All Cause Readmission 2) Diabetes Self-Management. For the QExA Plans, the PIP topic will be the ongoing PIPs for Diabetes and BMI for the EQRO validation. The health plans provided a summary of their PIP work over the past year to Health Services Advisory Group (HSAG) during this quarter.

2. HEDIS – The following steps occurred this quarter to finalize the HEDIS results for 2014:
    - On-site reviews at all five health plans;
    - Health plans submit preliminary measure results due to HSAG;
    - Health plans complete medical record abstraction for all measures; send final numerator-compliant counts for all measures; and send exclusions and numerator-compliant lists for selected measures to HSAG for medical record validation;
    - Health plans receive list of records chosen for medical record validation;
    - Health plans submit selected medical records to HSAG for validation;
    - Health plans complete all corrective actions and follow-up requests for final MCO-locked IDSS submission to HSAG;
    - Health plans submit signed HEDIS Roadmap Attestation to HSAG lead auditor;
    - Health plans submit rates for full set of measures required by MQD to HSAG; and
    - HSAG works with health plans to finalize IDSS; HSAG applies lock; plans mark as "final" for NCQA submission.

3. Compliance Monitoring – The EQRO completed the onsite review with each health plan from May 19 to June 6, 2014. This year the review requirements include 1) Provider Selection 2) Subcontracts and Delegation 3) Credentialing 4) Quality Assurance and Performance Improvement 5) Health Plan Information Systems 6) Practice Guidelines. HSAG staff in conjunction with MQD staff performed on-site reviews for compliance. MQD deemed the NCQA credentialing standards for four of the five health plans that are accredited by NCQA though HSAG performed credentialing oversight for some MQD specific standards.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) – The CAHPS survey for Adults was primarily conducted during second quarter of FFY14 with the survey closing on May 9, 2014.

5. Provider Survey – The mailing of the provider survey started on April 19, 2013 and as of May 31, 2013, the response rate was much lower than in 2011. To improve the response rate, MQD and the EQRO extended the provider survey by one week. On June 28, 2013, the provider survey closed. The total response rate was 14.05% (In 2011 the response rate was 18.4%). The EQRO issued the final report to MQD on October 24, 2013. One of the health plans performs significantly higher than the other four. Two of the health plans perform significantly lower than the other three. The EQRO will have health plans submit their corrective action plans for resolution of the provider survey in 2014.

6. The EQRO issued their final report to MQD on December 13, 2013. MQD provided a copy to CMS in December 2013. In addition, the final report is posted on the MQD website.

QUEST and QExA Dashboards
The MQD receives dashboards on both the QUEST and QExA programs monthly (see Attachment A and Attachment B for months April, May, and June 2014). These reports allow MQD to track provider network, claims processing, processing of prior authorization, and call center statistics at a glance.

Demonstration Evaluation
MQD submitted its final demonstration evaluation to CMS on January 24, 2014.

Enclosures/Attachments
Attachment A QUEST Dashboard- June 2014
Attachment B QExA Dashboard- June 2014

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QUEST Dashboard Report
SFY 2014 Monthly Trend Analysis

	Apr-14					May-14					Jun-14				
	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United	AlohaCare	HMSA	Kaiser	Ohana	United
# Members													June		
QUEST Adult	32,167	64,281	9,316	11,119	10,112	31,854	64,619	9,158	10,995	10,004	30,751	63709	8980	10,858	9,931
QUEST Keiki	40,817	87,802	17,481	4,875	4,369	39,358	86,402	17,024	4,838	4,320	37,396	84512	16563	4,764	4,288
Total	**72,984**	**152,083**	**26,797**	**15,994**	**14,481**	**71,212**	**151,021**	**26,182**	**15,833**	**14,324**	**68,458**	**148221**	**25543**	**15,622**	**14,219**
# Network Providers															
PCPs	549	766	229	584	636	550	757	229	584	635	554	752	215	586	634
Specialists	2,092	2,503	531	1,872	1,561	2,014	2,520	531	1,825	1,549	2,085	2543	531	1792	1,548
Behavioral Health	642	1,200	145	532	668	645	1,222	145	533	684	646	1239	147	547	671
Facilities (Hosp./NF)	34	24	52	51	46	34	24	52	51	46	35	24	52	51	46
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	1,471	1,119	321	1,317	982	1,478	1,122	321	1,292	1,028	1,476	1134	329	1311	1,029
Total # of providers	**4,788**	**5,612**	**1,278**	**4,356**	**3,893**	**4,721**	**5,645**	**1,278**	**4,245**	**3,942**	**4,796**	**5692**	**1274**	**4,287**	**3,928**
Call Center															
# Member Calls	4,240	14,594	460	2,462	1,621	4,157	15,051	394	2,194	1,723	4,571	14572	460	2,549	892
Avg. time until phone answered	0:00:14	0:27	0:00:10	0:00:11	0:00:07	0:00:17	1:16	0:00:13	0:00:12	00:10	0:00:23	1:07	0:00:13	0:00:10	00:05
Avg. time on phone with member	3:11:00	2:50:00	3:07:00	0:06:02	0:04:42	3:06:00	7:55:12	3:06:00	0:07:07	04:30	3:12	2:47	3:08	0:06	10:52
% of member calls abandoned	2.2%	2.42%	2.60%	2.60%	1.6%	2.6%	7.86%	2.60%	2.32%	2.1%	5.6%	7.99%	2.90%	3.6%	0.8%
# Provider Calls	9,033	15,118	N/A	248	1,000	8,699	16,276	N/A	231	1,224	8,492	12,085	N/A	233	337
Avg. time until phone answered	0:00:15	0:25	N/A	0:00:05	0:00:06	0:00:16	0:29	N/A	0:00:06	00:08	0:00:23	0:25	N/A	0:00:07	00:04
Avg. time on phone with provider	3:03:00	2:33:00	N/A	0:06:16	0:05:54	3:07:00	2:03:00	N/A	0:06:51	05:53	3:18	2:05	N/A	0:07	09:07
% of provider calls abandoned	3.3%	3.23%	N/A	1.6%	5.10%	3.4%	4.51%	N/A	0.0%	7.1%	5.5%	3.08%	N/A	2.1%	0.6%
Medical Claims - Electronic															
# Submitted, not able to get into system	1,467	9,745	30	342	652	1,180	6,993	5	376	703	1,571	11,957	8	375	680
# Received	38,677	272,017	254	30,423	13,054	40,689	276,847	138	31,083	14,061	36,540	268,834	243	30,678	13,618
# Paid	30,286	229,942	150	21,252	11,257	37,923	288,823	86	22,424	12,354	33,509	230,230	156	20,539	11,308
# In Process	9,510	129,878	97	7,847	57	4,543	96,379	89	8,239	69	5,005	116,717	159	11,656	82
# Denied	1,903	18,253	6	7,467	1,805	2,766	21,426	3	8,179	2,023	2,459	18,141	4	7,944	1,903
Avg time for processing claim in days (month to date)	4	11	13	7	9	4	11	13	7	8	4	12	14	10	8
Medical Claims - Paper															
# Submitted, not able to get into system	448	2,965	301	293	93	468	4,216	99	303	85	486	3,525	94	294	86
# Received	20,305	52,912	2,563	6,811	1,862	20,045	42,821	2,622	8,420	1,718	21,757	35,374	2789	7,941	1,723
# Paid	18,057	48,689	1,521	5,247	1,277	17,754	48,238	1,632	4,870	1,518	19,814	38,742	1786	4,712	1,234
# In Process	5,973	30,520	980	1,879	14	5,857	25,214	1,692	2,873	19	5,273	25,244	1828	2,969	20
# Denied	2,313	7,019	63	2,422	513	2,291	6,318	60	2,396	317	2,548	5,582	41	3,133	307
Avg time for processing claim in days (month-to-date)	7	16	13	7	10	7	18	13	8	14	8	21	14	10	12
Prior Authorization (PA)- Electronic															
# Received	110	309	121	2	15	105	297	378	10	4	91	261	109	14	5
# In Process	16	133	0	0	2	11	98	0	0	0	13	102	0	0	1
# Approved	93	233	116	2	11	93	276	375	9	4	78	215	105	14	4
# Denied	1	53	5	0	2	1	57	3	1	0	0	43	4	0	0
Avg time for PA in days (month to date)	7	15	4	1	5	7	11	3	0	1	6	10	5	1	4
Prior Authorization (PA)- Paper and Telephone															
# Received	3,298	904	2	187	1,179	3,212	692	4	199	1,127	3,004	682	2	182	1,117
# In Process	694	0	0	3	83	545	4	0	0	9	640	0	0	2	29
# Approved	2,585	721	0	182	1,066	2,650	549	0	195	1,084	2,350	543	0	178	1,058
# Denied	19	183	2	2	30	17	161	4	4	34	14	143	2	2	30
Avg time for PA in days (month-to-date)	4	1	14	3	3	4	1	13	4	3	5	0	9	4	3
# Non-Emergency Transports															
Ground	451	635	46	600	680	527	531	24	555	870	583	604	27	520	784
Air	477	620	6	106	61	428	519	0	109	81	469	648	0	109	74
* round trip															
# Member Grievance															
# Received	17	6	6	4	3	17	5	10	8	4	8	8	8	8	4
# Resolved	34	10	6	8	3	21	4	10	4	2	10	7	5	8	4
# Outstanding	8	4	1	3	2	5	5	1	7	4	3	6	4	7	4
# Provider Grievance															
# Received	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0
# Resolved	0	1	0	0	0	2	2	0	0	0	0	1	0	0	0
# Outstanding	2	2	0	0	0	0	1	0	0	0	0	0	0	0	0
# Member Appeals															
# Received	2	38	0	0	3	0	31	0	1	2	1	28	5	1	2
# Resolved	1	30	1	0	1	1	31	0	0	3	1	36	1	1	2
# Outstanding	2	24	0	0	3	1	24	0	1	2	1	16	4	1	2
# Provider Appeals															
# Received	1	2	0	14	15	0	1	0	6	21	0	3	0	16	15
# Resolved	0	4	0	11	27	1	2	0	12	20	0	0	0	20	13
# Outstanding	1	3	0	23	9	0	2	0	25	10	0	5	0	21	12
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits (A) - per 1,000	73	125	2	118	117	71	130	2	118	126	69	124	2	134	95
Inpatient Acute Days (A) - per 1,000	294	524	12	638	812	308	595	12	550	611	302	499	9	659	513
Inpatient Acute Psych Admits (A)- per 1,000	5	1	0	12	9	6	1	0	16	10	7	1	0	12	5
Inpatient Acute Psych Days (A)- per 1,000	25	7	1	39	33	20	7	3	35	73	30	6	3	37	27
Readmissions within 30 days (A)	26	300	0	22	9	23	307	0	28	4	32	249	0	22	4
Waitlisted Days (A) - per 1,000	40	8	1	0	12	46	12	0	0	10	50	7	0	0	10
ER Visits (C) - per 1,000	505	432	19	632	577	556	463	19	657	517	520	470	19	600	531
# Prescriptions (C) - per 1,000	7,911	9,439	664	8,519	7,818	7,964	9,681	673	8,767	8,634	7,013	9293	630	8,298	8,437

Legend:
ER= Emergency Room
Hosp= Hospital
PCP= Primary Care Provider
Psych= Psychiatric

Many health plans report utilization or frequency of services on a per 1000 members basis. This allows for a

as of: 6/30/2014

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	87	24	2		11	19	10	**153**
PCPs (accepting new members)	175	28	7	1	25	22	29	**287**
Specialists	936	87	18	1	71	68	64	**1,245**
Specialists (accepting new members)	630	78	6	1	43	34	48	**840**
Behavioral Health	115	26	1	1	10	12	14	**179**
Behavioral Health (accepting new members)	284	54	3	2	31	47	46	**467**
Facilities (Hosp./NF)	21	1	1	1	4	1	6	**35**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	980	161	22	12	102	108	91	**1,476**
Totals	**2,139**	**299**	**44**	**15**	**198**	**208**	**185**	**3,088**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	35,819	9,727	2232	499	5,972	7,200	7,009	**68,458**

# Members per PCP by Island	Oahu	Maui			Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	137	187	248	499	166	176	180	**156**

Note: RFP requirement is 300 members for every PCP

HMSA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	471	58	8	18	48	74	75	**752**
PCPs (accepting new members)	191	11	4	1	40	9	33	**289**
Specialists	1705	220	40	12	171	156	239	**2,543**
Specialists (accepting new members)	1705	220	40	12	171	156	239	**2,543**
Behavioral Health	767	124	7	3	80	138	120	**1,239**
Behavioral Health (accepting new members)	767	124	7	3	80	138	120	**1,239**
Facilities (Hosp./NF)	11	2	1	1	3	1	5	**24**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	675	142	12	17	84	94	110	**1,134**
Totals	**3,629**	**546**	**68**	**51**	**386**	**463**	**549**	**5,692**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	93,497	8,081	542	102	8,067	23,312	14,620	148,221

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	199	139	68	6	168	315	195	197

Note: RFP requirement is 300 members for every PCP

as of: **6/30/2014**

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	**118**	**36**	**4**	**3**	**21**	**15**	**18**	215
PCPs (accepting new members)	112	35	4	3	21	15	18	208
Specialists	**386**	**57**	**1**	**0**	**44**	**19**	**24**	531
Specialists (accepting new members)	386	57	1	0	41	19	24	531
Behavioral Health	**101**	**17**	**0**	**1**	**11**	**9**	**8**	147
Behavioral Health (accepting new members)	**101**	**17**	**0**	**1**	**11**	**9**	**8**	147
Facilities (Hosp./NF)	**35**	**3**	**1**	**1**	**3**	**7**	**2**	52
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	**198**	**45**	**4**	**4**	**37**	**17**	**24**	329
Totals	**838**	**158**	**10**	**9**	**116**	**67**	**76**	**1,274**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	16,849	8,694						25,543

# Members per PCP by Island	Oahu	Maui			Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	143	242	0	0	0	0	0	119

Note: RFP requirement is 300 members for every PCP

OHANA HEALTH PLAN

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	380	53	3	6	48	66	30	**586**
PCPs (accepting new members)	161	21	3	1	21	21	10	**238**
Specialists	1446	86	13	4	110	78	55	**1,792**
Specialists (accepting new members)	980	82	13	0	38	72	53	**1,238**
Behavioral Health	394	35	1	0	24	62	31	**547**
Behavioral Health (accepting new members)	323	32	1	0	18	51	25	**450**
Facilities (Hosp./NF)	27	5	2	1	7	2	7	**51**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	850	132	17	0	80	115	117	**1,311**
Totals	**3,097**	**311**	**36**	**11**	**269**	**323**	**240**	**4,287**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	8,981	2,084	155	37	1,023	1,878	1,464	**15,622**

# Members per PCP by Island	Oahu	Maui			Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	24	39	52	6	21	28	49	**27**

Note: RFP requirement is 300 members for every PCP

as of: **6/30/2014**

UNITED HEALTHCARE COMMUNITY PLAN

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	501	50	9	6	65	63	40	**734**
PCPs (accepting new members)	423	45	7	6	61	33	36	**611**
Specialists	1524	110	40	2	171	90	86	**2,023**
Specialist (accepting new members)	1225	109	38	2	169	68	83	**1,694**
Behavioral Health	527	72	2	2	24	63	35	**725**
Behavioral Health (accepting new members)	515	67	1	1	23	59	34	**700**
Facilities (Hosp./NF)	36	6	4	0	5	10	7	**68**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	886	91	9	8	98	93	79	**1,264**
Totals	**3,474**	**329**	**64**	**18**	**363**	**319**	**247**	**4,814**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	8,336	1,809	116	29	924	1,731	1,274	**14,219**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	17	36	13	5	14	27	32	**19**

Note: RFP requirement is 300 members for every PCP

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	April '14		May '14		June '14	
	Ohana	United	Ohana	United	Ohana	United
# Members						
Medicaid	10,419	7,006	10,426	7,060	10,548	7,061
Duals	15,238	15,803	15,391	15,902	15,277	15,933
Total Members	**25,657**	**22,809**	**25,817**	**22,962**	**25,825**	**22,994**
# Network Providers						
PCPs (incl FQHC less est 100 FQHC PCPs)	559	825	556	820	557	813
Specialists	2212	2,320	2187	2,335	2141	2,324
Facilities (Hosp./NF)	63	46	63	46	63	46
Foster Homes (FH) (CCFHH only; no E-ARCH)	1000	1,003	999	1,010	1011	1,024
HCBS Providers (All LTC, except CCFHH and NF)	156	284	156	288	157	288
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,618	1016	1,590	1,050	1,622	1,054
Total # of providers	**5,608**	**5,494**	**5,551**	**5,549**	**5,551**	**5,549**
Call Center						
# Member Calls	9,467	4,317	8,693	4,562	9,697	3,470
Avg. time until phone answered	0:00:12	00:08	0:00:12	00:11	0:00:11	00:12
Avg. time on phone with member	0:06	0:07	0:07	07:45	0:06	11:59
% of member calls abandoned	3%	1.7%	3%	3.1%	4%	1.0%
# Provider Calls	4,482	1,940	4,213	2,054	4,609	2,454
Avg. time until phone answered	0:00:16	00:08	0:00:26	00:10	0:00:30	00:10
Avg. time on phone with provider	0:07	0:08	0:07	09:09	0:08	11:59
% of provider calls abandoned	2%	1.0%	2%	2.3%	3%	0.8%
Medical Claims- Electronic						
# Submitted, not able to get into system	2,401	2,240	2,109	2,139	2,085	2,195
# Received	147,058	44,802	151,626	42,799	141,421	43,904
# Paid	81,178	39,863	83,261	31,713	75,168	32,643
# In Process	47,914	853	46,736	841	54,976	880
# Denied	63,942	11,999	54,248	9,448	54,635	10,702
Avg time for processing claim in days	9	10	10	9	10	11
* unable to break out (month to date)						
Medical Claims- Paper						
# Submitted, not able to get into system	1,155	884	2,875	1,086	1,111	1,263
# Received	49,945	17,693	56,794	21,723	62,667	25,269
# Paid	22,570	11,789	18,779	15,382	19,424	16,867
# In Process	19,655	1,773	23,047	1,811	25,287	1,867
# Denied	37,546	4,810	26,855	5,809	38,723	6,689
Avg time for processing claim in days	8	11	8	8	11	8
(month-to-date)						
Prior Authorization (PA)- Electronic						
# Received	50	49	30	47	52	32
# In Process	0	11	1	2	2	1
# Approved	48	37	27	44	49	31
# Denied	2	1	2	1	1	0
Avg time for PA in days	0	5	1	5	1	5
(month to date)						
Prior Authorization (PA)- Paper and Telephone						
# Received	678	3,846	711	4,171	677	4,316
# In Process	30	242	15	118	14	149
# Approved	637	3,350	658	3,787	631	3,930
# Denied	11	254	38	266	32	237
Avg time for PA in days	4	3	4	4	5	2
(month-to-date)						
# Non-Emergency Transports						
Ground	9,552	15,778	9,583	16,415	8,941	15,471
Air	513	395	488	333	571	341
* round trip						
# Member Grievance						
# Received	64	65	76	81	101	68
# Resolved	54	37	58	72	75	82
# Outstanding	52	34	70	43	96	29
# Provider Grievance						
# Received	2	5	4	0	0	0
# Resolved	1	2	1	2	1	3
# Outstanding	2	5	5	3	4	0
# Member Appeals						
# Received	7	17	6	17	1	3
# Resolved	5	22	8	11	1	20
# Outstanding	6	14	4	20	4	3
# Provider Appeals						
# Received	13	40	28	60	27	55
# Resolved	2	58	27	45	18	53
# Outstanding	44	20	45	35	54	37
Utilization - based on Auth (A) or Claims (C)						
Inpatient Acute Admits * (A) - per 1,000	254	205	274	218	289	215
Inpatient Acute Days * (A) - per 1,000	937	1,494	1,194	1,402	1,285	1,469
Readmissions within 30 days* (A)	62	25	64	26	71	25
ER Visits * (C) - per 1,000**	994	1,922	1,133	2,261	1,009	1,874
# Prescriptions (C) - per 1,000	20,477	19,520	20,773	19,708	19,080	19,317
Waitlisted Days * (A) - per 1,000	168	77	155	83	201	75
NF Admits * (A)	3	4	2	1	3	4
# Members in NF (non-Medicare paid days) (C)**	1,390	1,182	1,377	1,197	1,311	1,182
# Members in HCBS **(C)- note: member can be included in more than one category listed below	2,258	2,570	2,208	2,552	2,083	2,426
# Members in FH **(C)	704	1,053	688	1,065	650	1,018
# Members in Self-Direction **(C)	855	890	838	886	859	866
# Members receiving other HCBS **(C)	1,403	975	1,370	969	1,224	889
NF Days (non-Medicare covered days) (C)						
(* non-Medicare) (**lag in data of two months)						

Legend:
- ER= Emergency Room
- FH=Foster Home
- HCBS= Home and Community Based Services
- Hosp= Hospital
- NF=Nursing Facility
- PCP= Primary Care Provider
- CMS 1500- physicians, case management agencies, RACCP homes, home health, etc.
- CMS UB04- nursing facilities, FQHC, hospitals

Many health plans report utilization or frequency of services on a per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis.

* Duplicates included

as of: **June 30, 2014**

Ohana Health Plan

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	Hawaii	Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	341	54	5	3	48	74	32	**557**
PCPs (accepting new members)	171	20	3	1	18	20	10	**243**
Specialists	1,725	114	14	0	101	110	77	**2,141**
Specialists (accepting new members)	1,601	103	14	0	100	94	76	**1,988**
Facilities (Hosp./NF)	36	5	2	1	7	4	8	**63**
Foster Homes (FH) (CCFFH only; no ARCH)	847	41	0	0	14	82	27	**1,011**
HCBS Providers (All LTC, except CCFFH and NF)	109	9	2	0	6	23	8	**157**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,043	157	18	6	112	151	135	**1,622**
Totals	**4,101**	**380**	**41**	**10**	**288**	**444**	**287**	**5,551**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	16,994	2,436	395	86	970	3,496	1,448	**25,825**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	50	45	79	29	20	47	45	**46**

Note: RFP requirement is 600 members for every PCP

UnitedHealthcare Community Plan

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC)	668	58	9	6	88	71	46	**946**
PCPs (accepting new members)	564	49	8	6	84	49	35	**795**
Specialists	2,208	184	42	3	204	162	141	**2,944**
Specialist (accepting new members)	2,124	183	42	3	202	140	139	**2,833**
Facilities (Hosp./NF)	42	8	4	0	3	7	5	**69**
Foster Homes (FH) (xARCH)	861	35	0	0	18	93	22	**1,029**
HCBS Providers (All LTC, xFH & NF)	233	16	0	0	9	28	5	**291**
Ancilliary & Other (All not listed above)	875	115	10	8	98	106	93	**1,305**
Totals	**4,887**	**416**	**65**	**17**	**420**	**467**	**312**	**6,584**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	15,239	1,550	0	0	1,314	3,587	1,304	**22,994**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	23	27	0	0	15	51	28	**24**

as of: **June 30, 2014**

Ohana Health Plan

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	575	84	3	7	38	96	35	**838**
Network (provider look up, access)	89	23	1	0	1	13	7	**134**
Primary Care Physician Assignment or Change	297	45	4	1	16	60	35	**458**
NEMT (inquiry, scheduling) -*monthly report*	4010	42	12	1	5	106	0	**4176**
Authorization/Notification (prior auth status)	32	40	6	5	18	49	36	**186**
Eligibility (general plan eligiblity, change request)	97	8	1	1	2	16	5	**130**
Benefits (coverage inquiry)	183	28	3	1	14	41	24	**294**
Enrollment (ID card request, update member information)	459	85	7	1	23	122	40	**737**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	182	42	5	2	6	41	21	**299**
Billing/Payment/Claims	67	15	1	0	3	15	4	**105**
Appeals	6	3	0	0	0	6	0	**15**
Complaints and Grievances	23	9	0	0	0	10	7	**49**
Other	1147	189	19	10	64	265	110	**1804**
Totals	**7,167**	**613**	**62**	**29**	**190**	**840**	**324**	**9,225**

UnitedHealthcare Community Plan

United Healthcare Community Plan

Summary of Calls by Island	Oahu	Maui	Kauai	Lanai	Molokai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	4	0	7	1	0	4	3	**19**
Network (provider look up, access)	38	10	11	2	4	5	3	**73**
Primary Care Physician Assignment or Change	218	16	21	2	2	65	20	**344**
NEMT (inquiry, scheduling) -*monthly report**	3,333	275	145	14	6	720	581	**5,074**
Authorization/Notification (prior auth status)	89	12	13	1	3	31	14	**163**
Eligibility (general plan eligiblity, change request)	466	61	80	6	15	120	49	**797**
Benefits (coverage inquiry)	709	80	196	10	49	228	101	**1,373**
Enrollment (ID card request, update member information)	486	68	90	3	13	142	58	**860**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	109	14	20	0	1	32	8	**184**
Billing/Payment/Claims	910	81	208	11	50	206	24	**1,490**
Appeals	0	0	0	0	0	0	0	**0**
Complaints and Grievances	0	0	0	0	0	0	0	**0**
Other	258	24	38	5	16	72	28	**441**
Totals	**6,620**	**641**	**829**	**55**	**159**	**1,625**	**889**	**10,818**

*Calls logged via Logisticare call center