Hawaii QUEST Expanded
Section 1115 Draft Annual Report
September 30, 2014

Demonstration Reporting Period:
Demonstration Year: 19 (7/1/2012 – 6/30/2013)

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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 19, 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 19.

The MQD performed its fourth 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
- Chlamydia Screening
- Comprehensive Diabetes Care:
  - LDL Control <100 mg/dl
  - HbAIC Control (<8%)
  - Systolic and Diastolic BP Levels <140/90
- Controlling High Blood Pressure
- Emergency Department Visits/1000
- Getting Needed Care

Measure	Time Frame	AlohaCare	HMSA	Kaiser	‘Ohana	United
Childhood Immunization	January to June 2012	No	No	Yes	N/A	N/A
	July to Dec.2012	No	No	Yes	N/A	N/A
Chlamydia Screening in Women	January to June 2012	No	Yes	Yes	N/A	N/A
	July to Dec.2012	No	No	Yes	N/A	N/A
Comprehensive Diabetes Care						
LDL Control <100 mg/dl	January to June 2012	No	No	Yes	N/A	N/A
	July to Dec.2012	No	No	Yes	N/A	N/A
HbA1C Control (<8%)	July to Dec.2012	No	No	Yes	N/A	N/A
Systolic and Diastolic BP Levels < 140/90	July to Dec.2012	No	No	Yes	N/A	N/A
Controlling High Blood Pressure	July to Dec.2012	No	No	Yes	N/A	N/A
ED Visits/1000 (Ambulatory Care Measure)	January to June 2012	Yes	Yes	Yes	N/A	N/A
Getting Needed Care	January to June 2012	No	No	Yes	N/A	N/A
	July to Dec.2012	No	No	Yes	No	No

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 for January to June 2012 and $0.40 PMPM for improvement in each of the areas listed above for a maximum of $2.00 PMPM for July to December 2012. Improvement is not required in all areas to receive the financial incentive.

In demonstration year 19, the health plans received financial incentives for performance improvement (see table above).

Outreach/Enrollment Activities

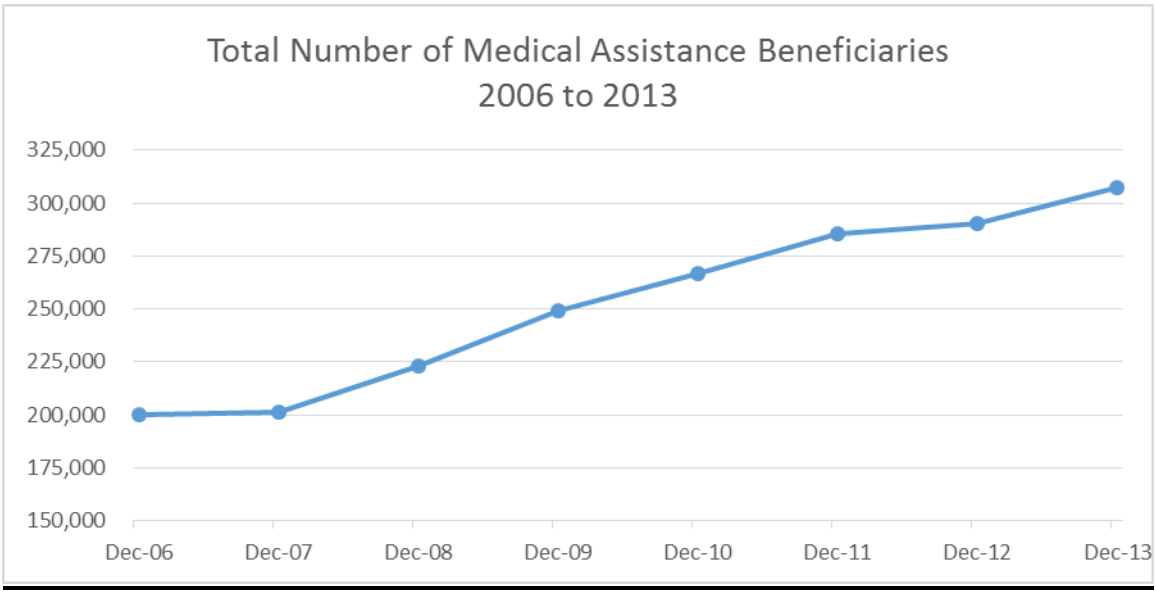
This annual report includes information on the outreach and enrollment for the Demonstration. The DHS continues to collaborate with the Federally Qualified Health Centers (FQHCs) to increase Medicaid enrollment. During SFY13, the Department received 8,602 medical applications from FQHCs. This is a decrease of approximately 7% since SFY12. 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 and SFY13 may be seen as a return to more consistent levels of applications being submitted by the FQHCs.

The Demonstration had a 14.8% 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 54% since December 2006. See chart below for visual of the increase in enrollment of the Demonstration program in Hawaii.

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



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 2013 measures, including the validated HEDIS 2013 measures, is attached in Attachment A. Below is more detailed information regarding HEDIS.

The MQD performed two Child CAHPS surveys in the spring of 2013. One for the QUEST and QExA programs and one for CHIP enrollees. Members of both the QUEST and QExA health plans that are Medicaid children were provided an opportunity to participate in this survey. CHIP enrollees of both QUEST and QExA had their own survey for reporting to CMS. The CHIP report is Statewide and not by health plan due to limited enrollment. See Attachment B for a copy of the QUEST, QExA, and CHIP 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 2013

The most recent reported HEDIS year for QUEST & QExA is HEDIS 2013. 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)

Measures

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

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

HEDIS Measures

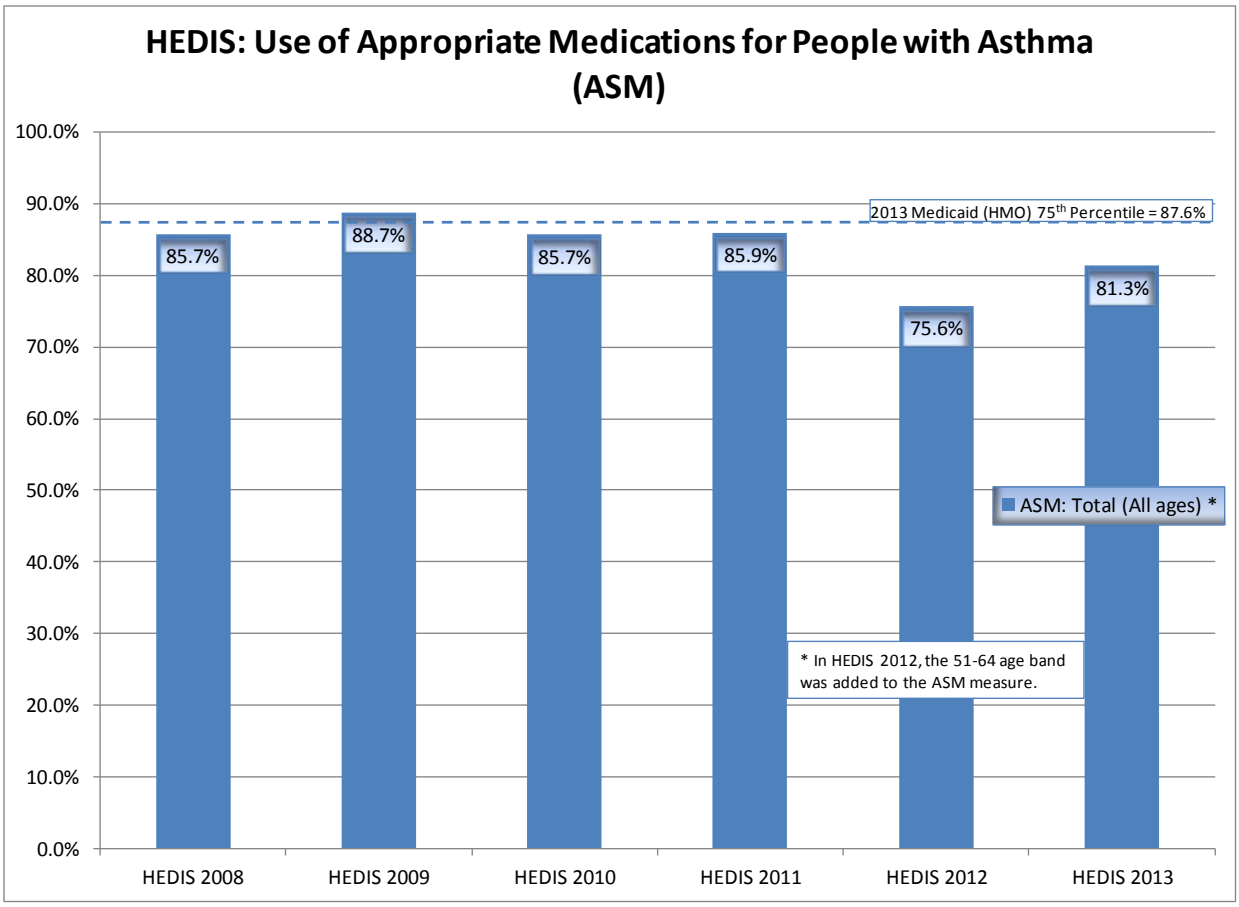
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

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

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

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

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



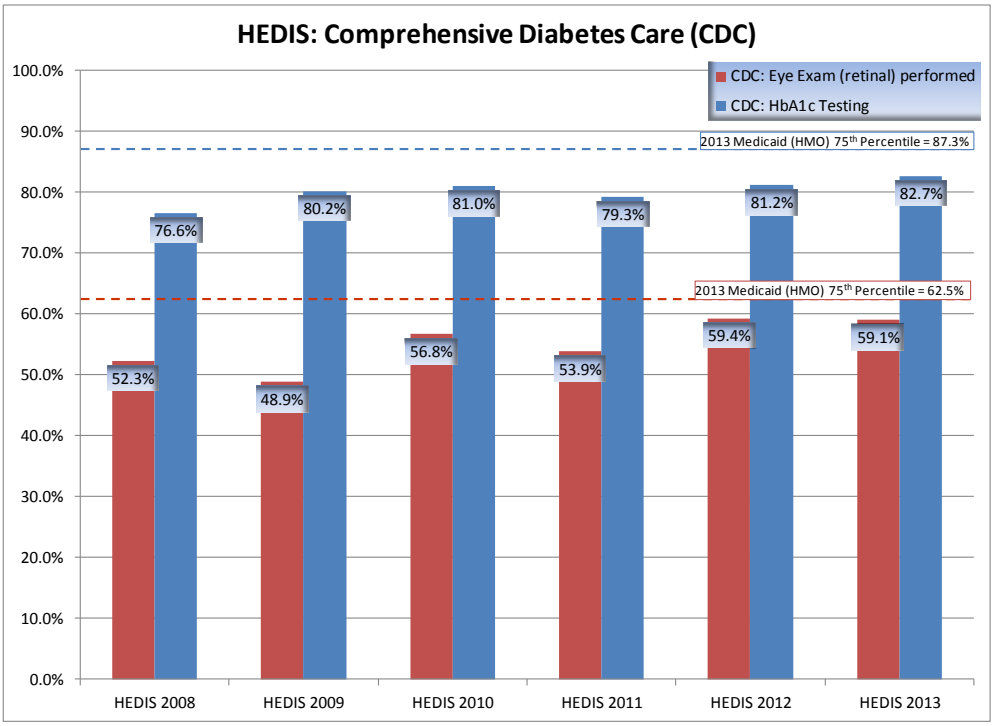
ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2013, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have substantially increased the rates in 2012 or 2013.

- The 2013 year's score have started to increase from the low value in 2012. The raise is moving the HEDIS values more consistently towards the previous four-year range between 85% and 88%.

- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 87.6% that is consistent with the previous years reported.

CDC – Eye Exam:



- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed varied between 48% and 60% from 2008 to 2013, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported a rate consistent with 2012. The first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 62.5%.

CDC – HbA1c Testing:

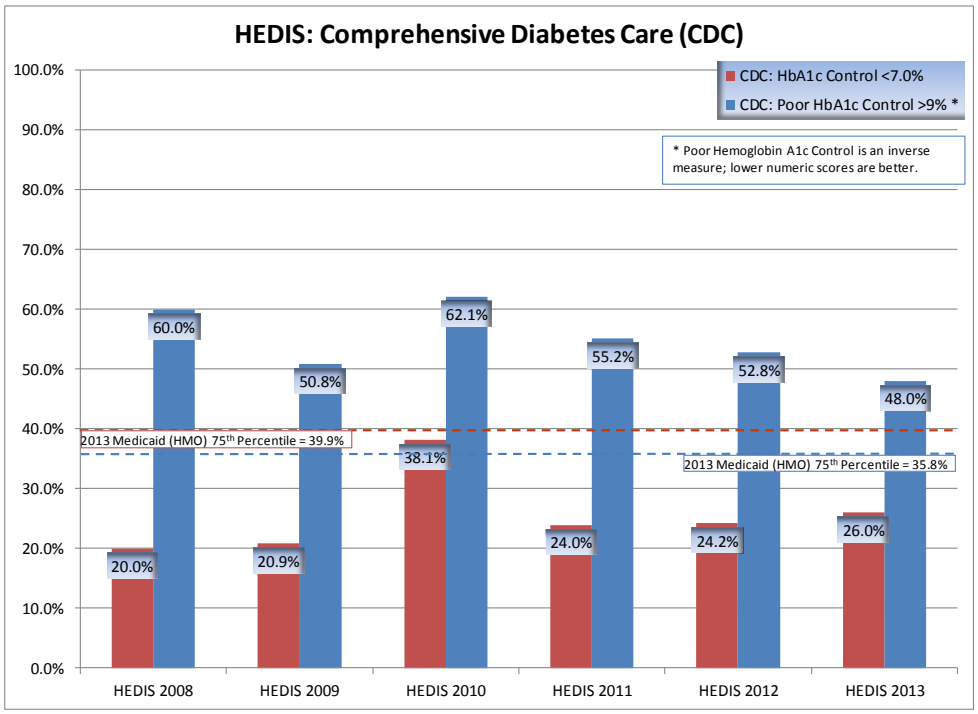
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 83% from 2008 to 2013, with the highest rate of 82.7% occurring in 2013 and the lowest rate of 76.6% occurring in 2008.

- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 87.3% that is above all of the years reported.

CDC – HbA1c Control <7.0%:

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



- There is a moderate uptrend in the rates of the six years reported. The latest year (2013) reported the highest rate (except for the outlier of 38.1% in 2010), and the earliest year (2008) reported the lowest rate. In 2010, the rate of 38.1% seems like an outlier score especially when considering the five other years' scores were between 20.0% and 26%

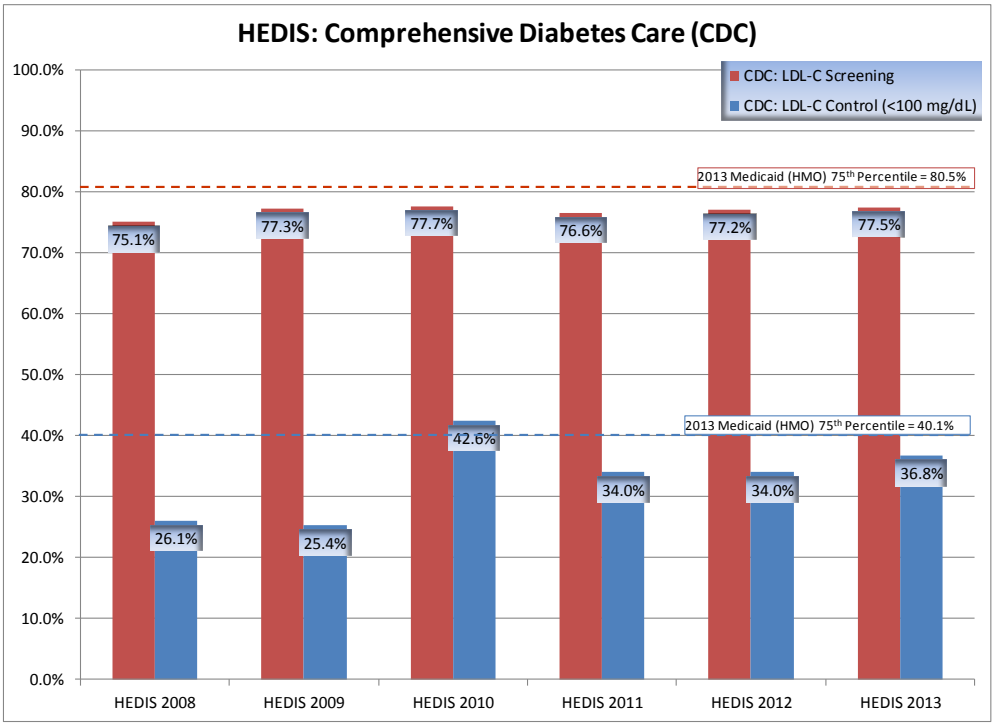
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 39.9% that is above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 48% from 2008 to 2013, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 48.0% occurring in 2013. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a slight downtrend (good) to flat trend in the rates of the six years reported. The last four years' score went from 62.1% to 55.2% to 52.8% to 48.0%, with the lowest score occurring in 2013 (48.0%).

- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25th percentile of the national Medicaid population. For the 2013 this target was 35.8%, which is below (not good) all of the years reported.



CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 78% from 2008 to 2013, with the highest rate of 77.7% occurring in 2010 and the lowest rate of 75.1% occurring in 2008.

- There is a flat trend (no trend) in the rates of the six years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 80.5% that is higher than all of the years reported.

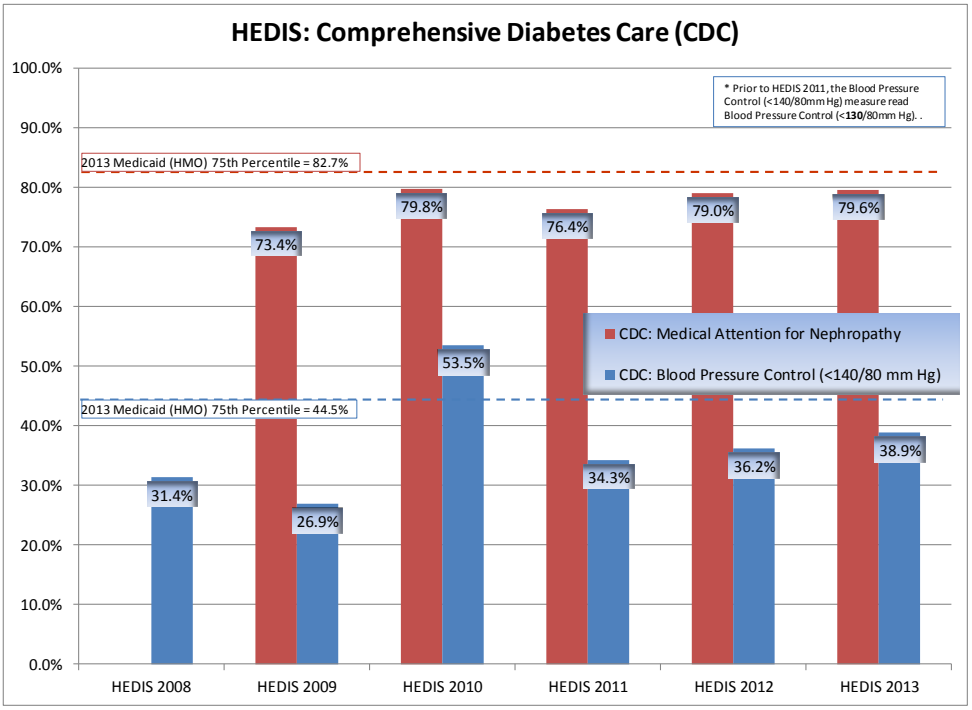
CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2013, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- There is a flat trend (no trend) in the rates of the six years reported. The last three years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with a national averages -- this target was 40.1% that is higher than all of the years reported (except for 2010 (42.6%)).

CDC – Medical Attention for Nephropathy:



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

- There is a slight up trend in the rates of the five years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2013) had a rate (79.6%) not much lower than the 79.8% in 2010.

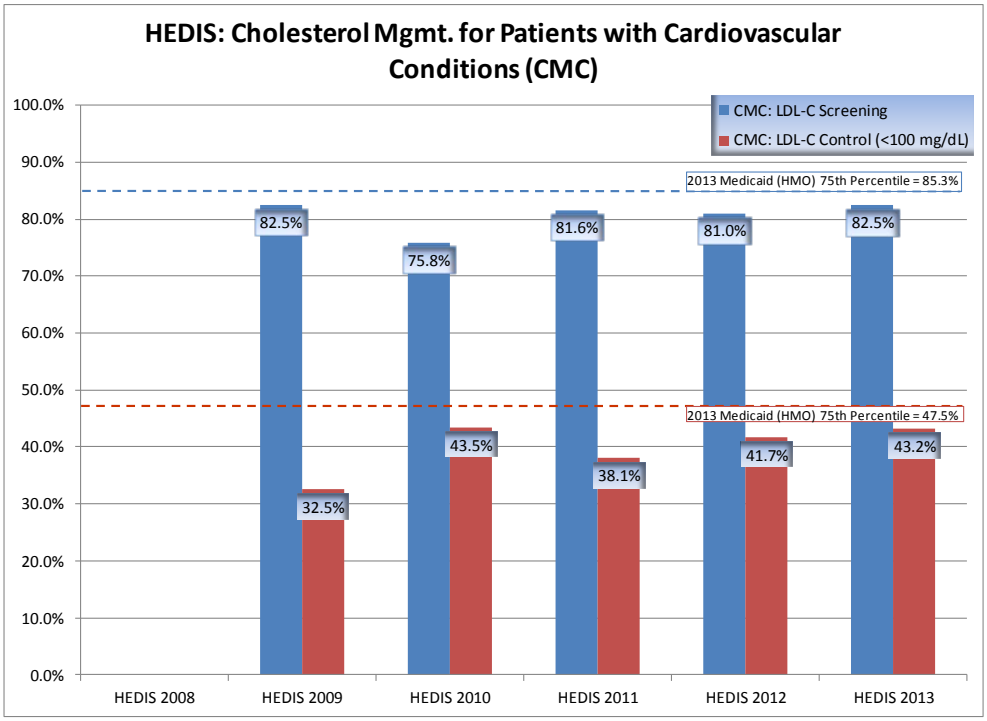
- The HI Quality Strategy target percentage for the Medical Attention for Nephropathy measure is the 75th percentile of the national Medicaid population. For the 2013 this target was 82.7% that is higher than all of the years reported.

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

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2013, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.

- There is a slight up trend in the rates of the six years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2012 (36.2%) and 2013 (38.9%).

- The HI Quality Strategy target percentage for the CDC Blood Pressure Control (<140/80 mm Hg) measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 44.5% that is higher than all of the years reported except for in 2010.



CMC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 83% from 2009 to 2013, with the highest rate of 82.5% occurring in 2009 (and 2013) and the lowest rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first and last year (2009 and 2013), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.

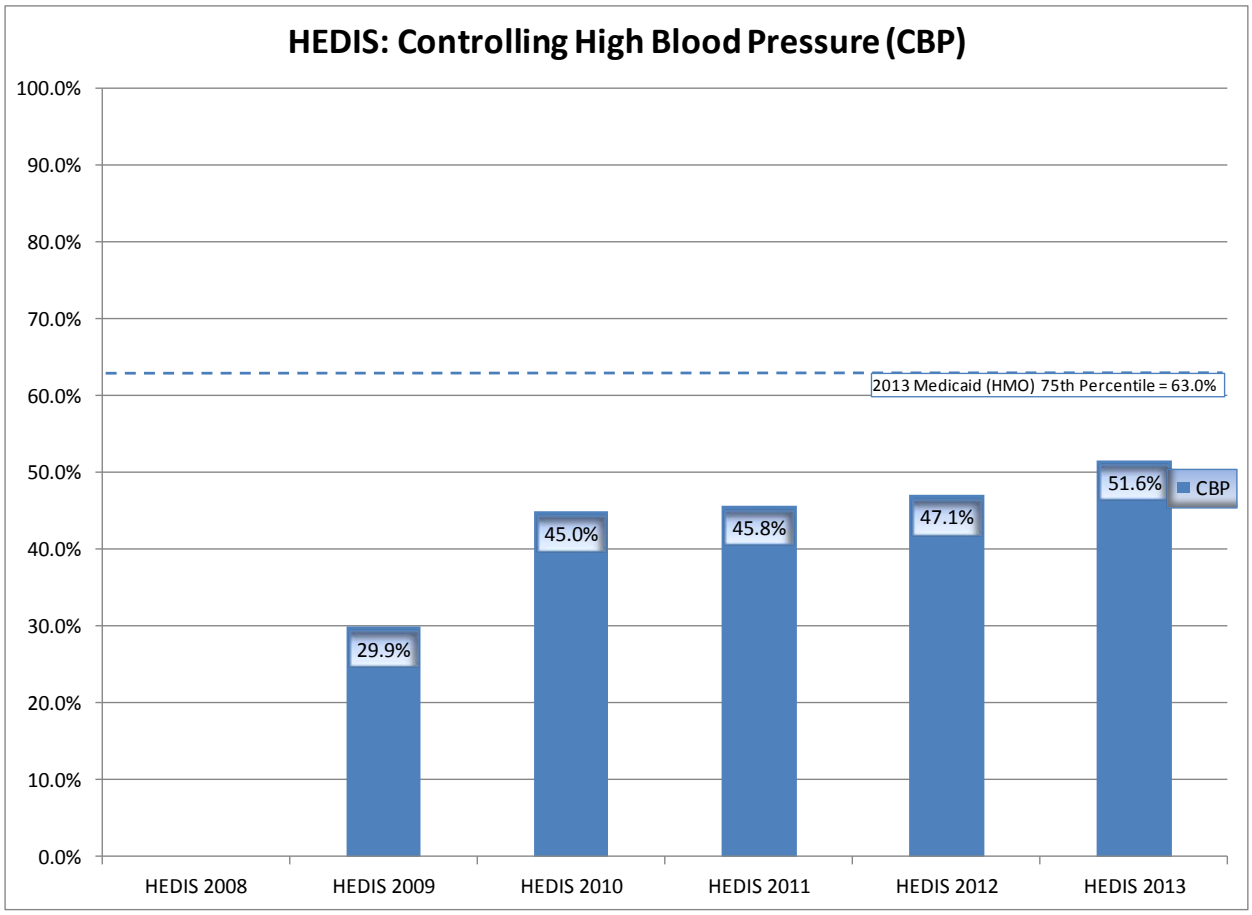
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 85.3% that is higher than all of the years reported.

CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 44% from 2009 to 2013, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.

- There is a slight up trend in the rates of the six years reported. The rate in 2013 (43.2%) is approaching the higher rate is 2010 (43.5%).

- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 47.5%.



CBP:

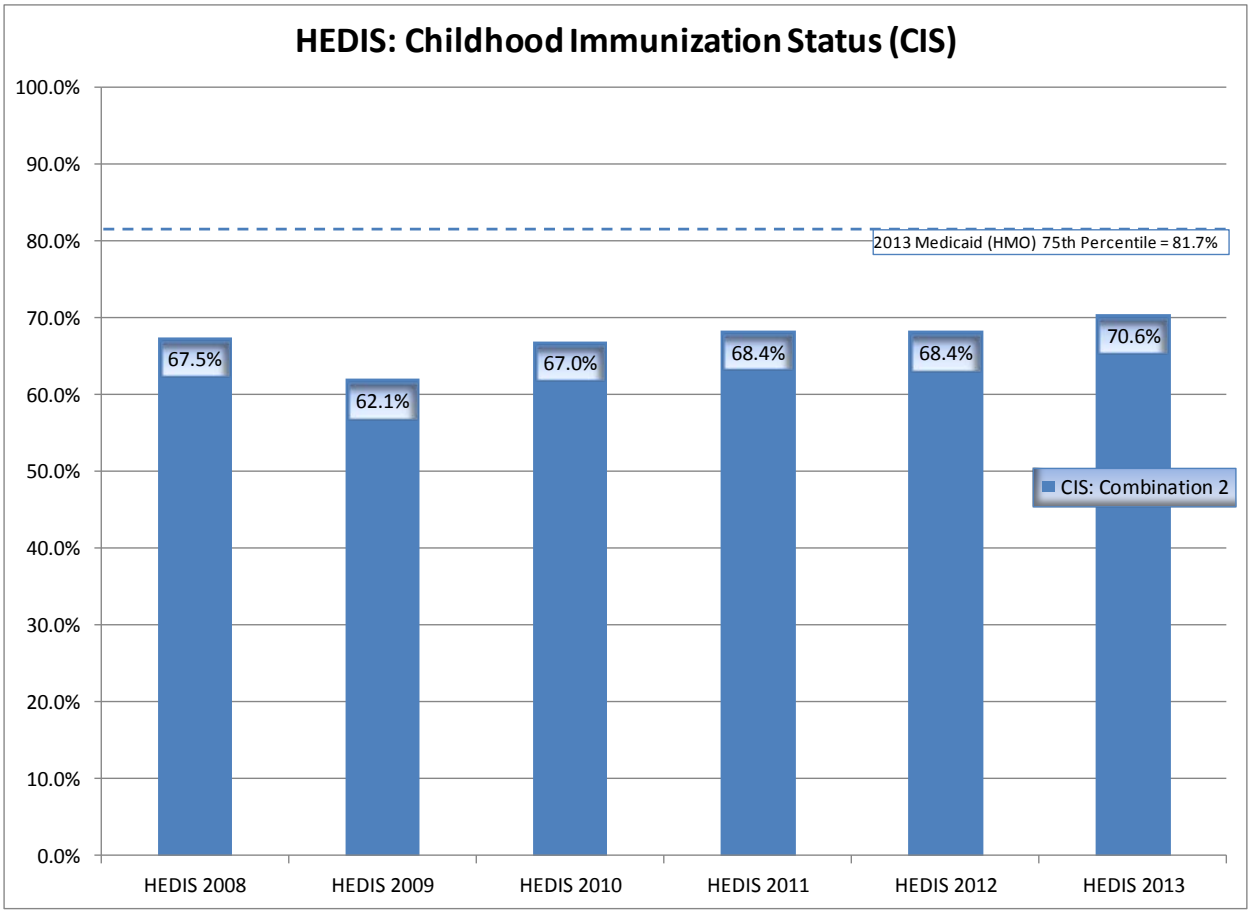
- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 52% from 2009 to 2013, with the highest rate of 51.6% occurring in 2013 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.

- There is a clear up trend in the rates of the six years reported. From 2009 thru 2013, each subsequent year's score is higher than the last.

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 63.0% that is higher than all of the years reported.

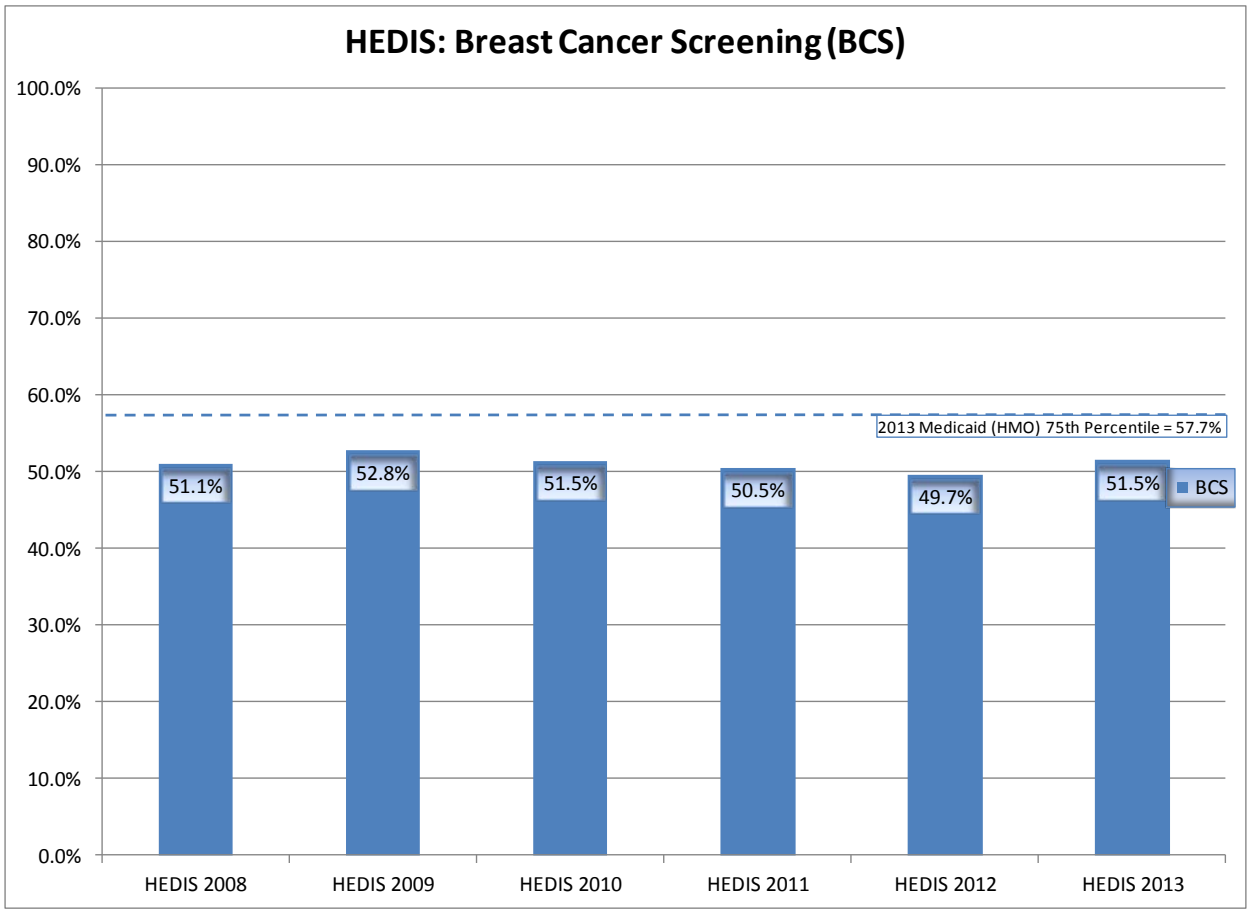
CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 71% from 2008 to 2013, with the highest rate of 70.6% occurring in 2013 and the lowest rate of 62.1% occurring in 2009.



- There is a slight up trend in the rates of the six years reported. Excluding the 2008 rate, the rates increased from 2009 to 2013 by 3.1 percentage points with no annual decreases.

- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 81.7% that is higher than all of the years reported.

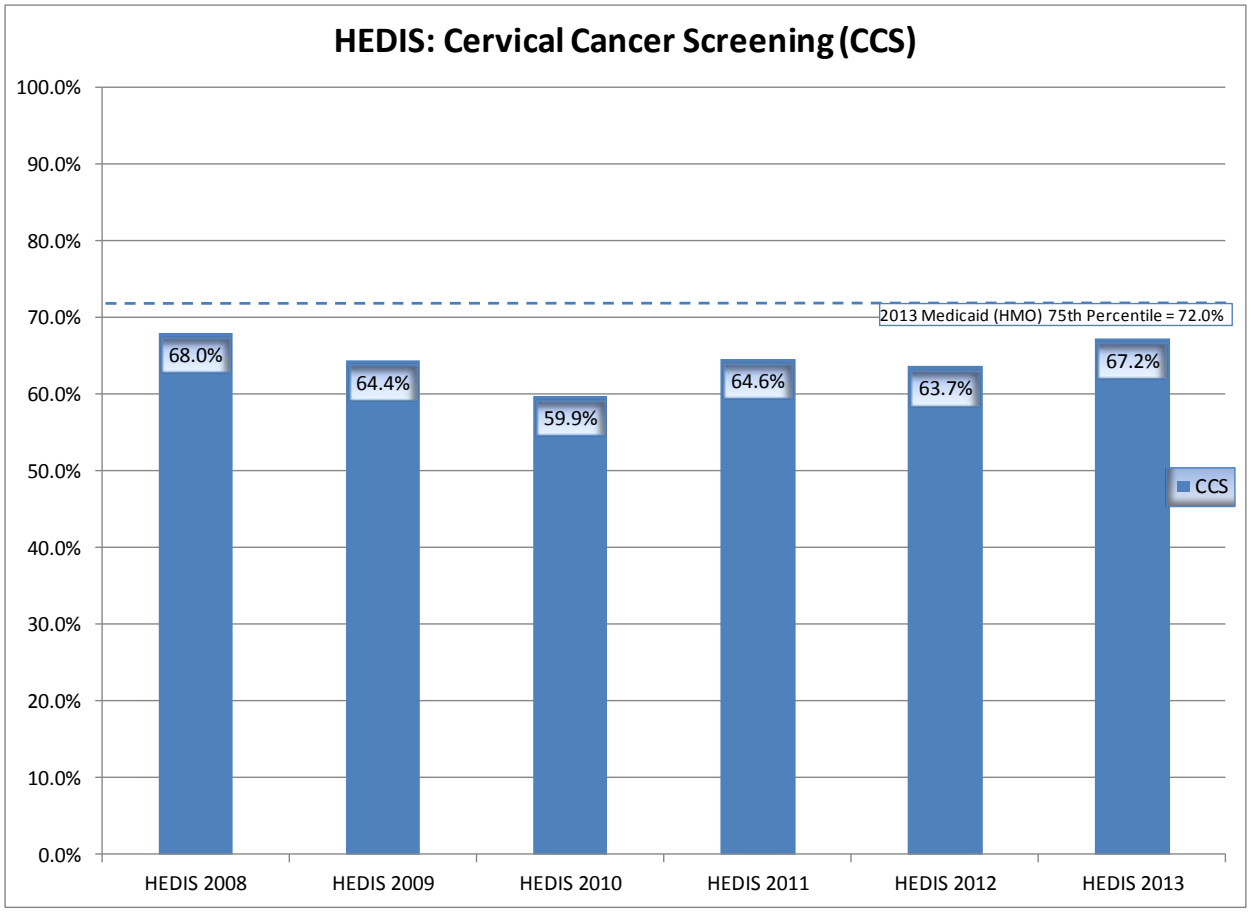


BCS:

- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 53% from 2008 to 2013, with the highest rate of 52.8% occurring in 2009 and the lowest rate of 49.7% occurring in 2012.

- There is a clear down trend in the rates for the first five years reported; the last year (2013 with 51.5%) shows strong improvement.

- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 57.7% that is higher than all of the years reported.

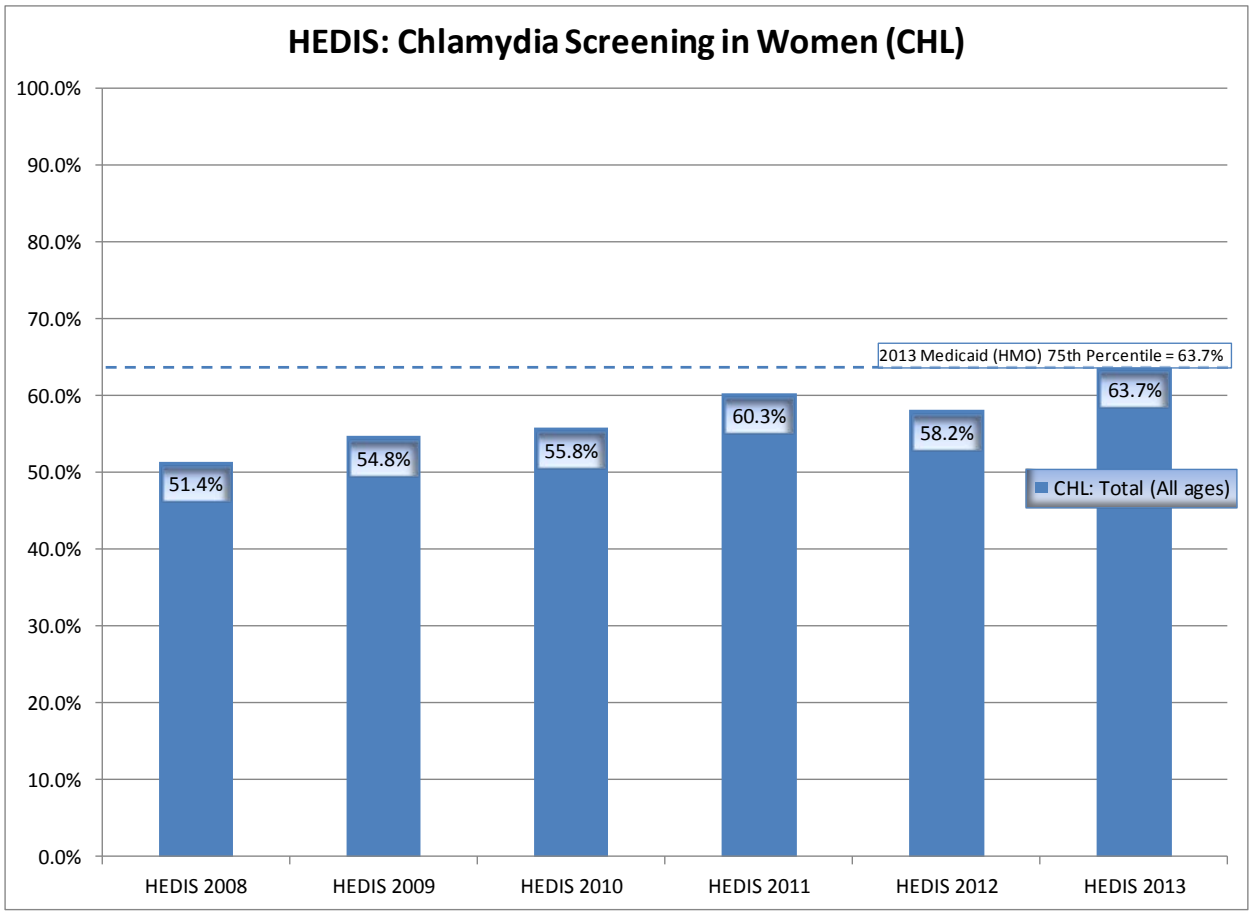


CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2013, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.

- There was a slight down trend in the rates of the first five years reported; the rate in 2013 (67.2%) increased to the previous trend in 2008 (68.0%).

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 72.0% that is higher than all of the years reported.



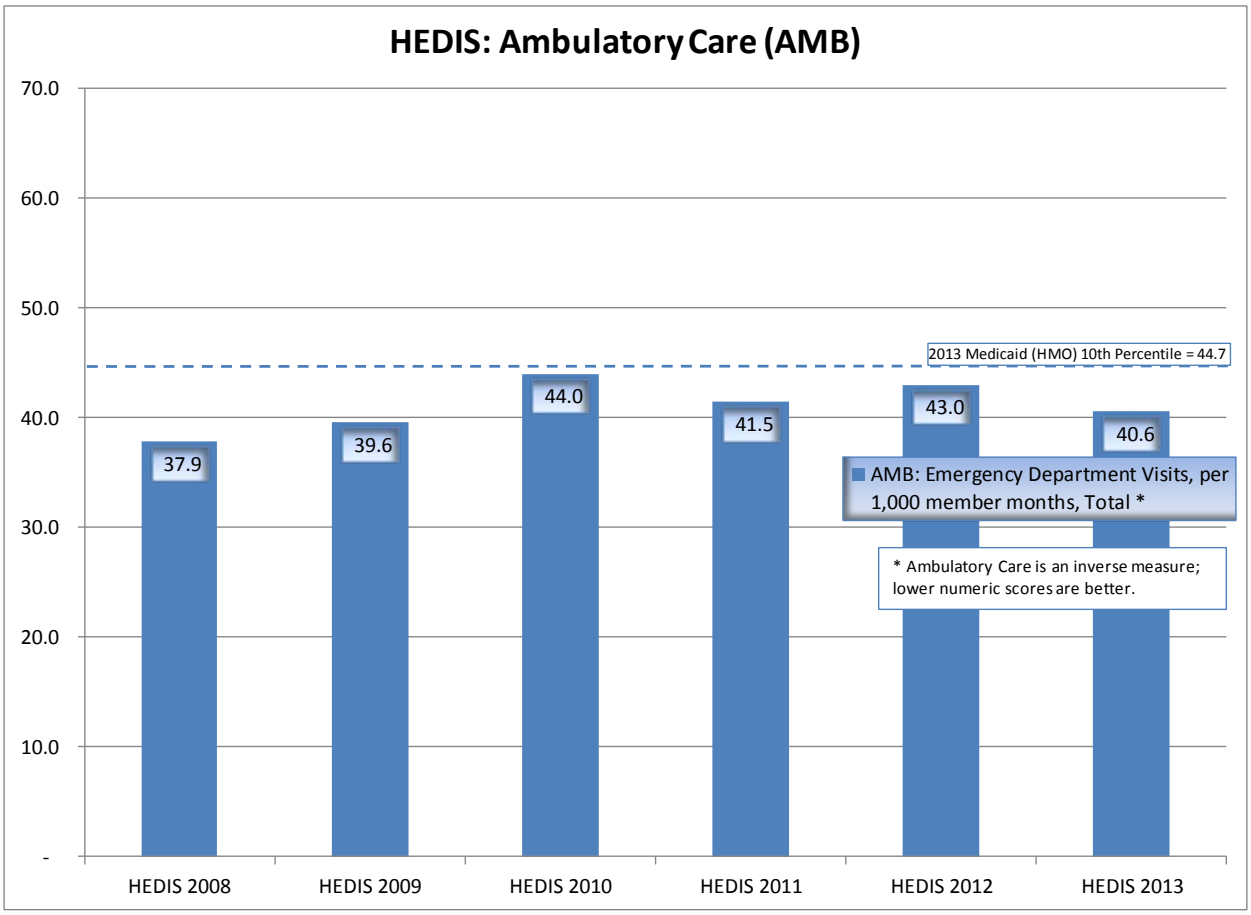
CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 64% from 2008 to 2013, with the highest rate of 63.7% occurring in 2013 and the lowest rate of 51.4% occurring in 2008.

- There is a clear up trend in the rates of the six years reported. The lowest rate (51.4%) is in 2008 and the highest rate (63.7%) is in 2013.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 63.7%. In 2013, HI met its quality strategy target.

AMB:



- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2013, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a clear up trend in the rates of the six years reported. The rate is 2013 (40.6%) is starting to trend downward again.

- The HI Quality Strategy target percentage for the CCS measure is the 10th percentile of the national Medicaid population. For the 2013 -- the latest year with national averages -- this target was 44.7, which is higher (good) than all of the years reported. HI met its quality strategy goal for ambulatory care.

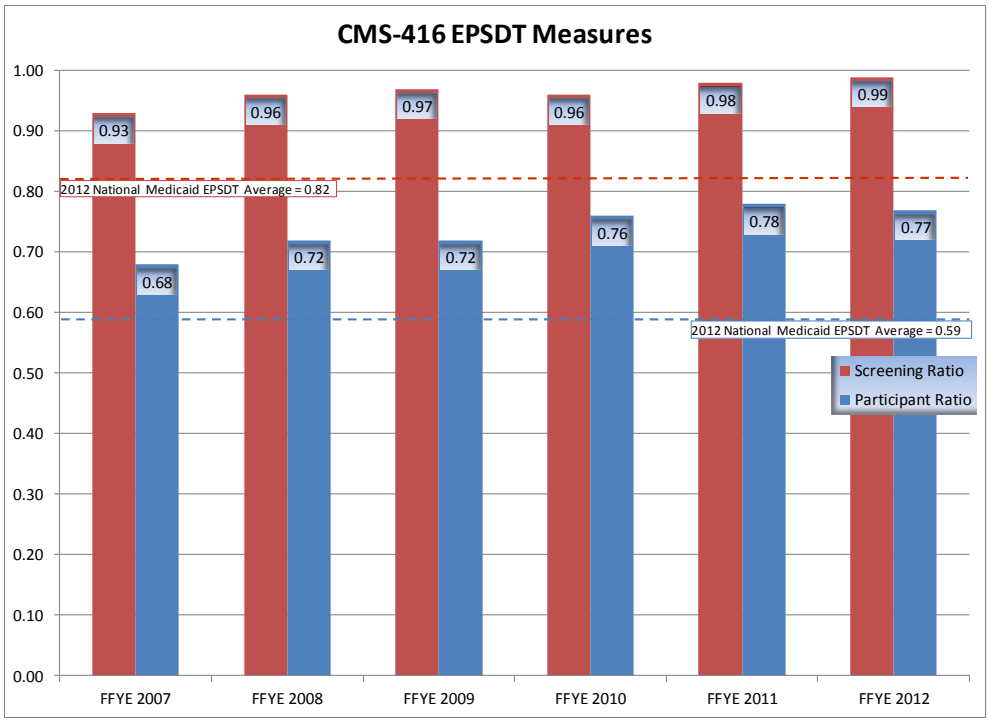
EPSDT Measures

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

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

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

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



EPSDT – Screening Ratio:

- The statewide Medicaid screening ratio from the EPSDT report varied between 0.93 and 0.99 from 2007 to 2012, with the highest rate of 0.99 occurring in 2012 and the lowest rate of 0.93 occurring in 2007.
- There is a clear up trend in the rates of the six years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.99 was reported in the last year (2012), with a mostly steady uptrend in between.
- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2012 – the latest reported year – then national average is 0.82, which is lower than all of the years reported.

EPSDT – Participant Ratio:

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

CAHPS Measures

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

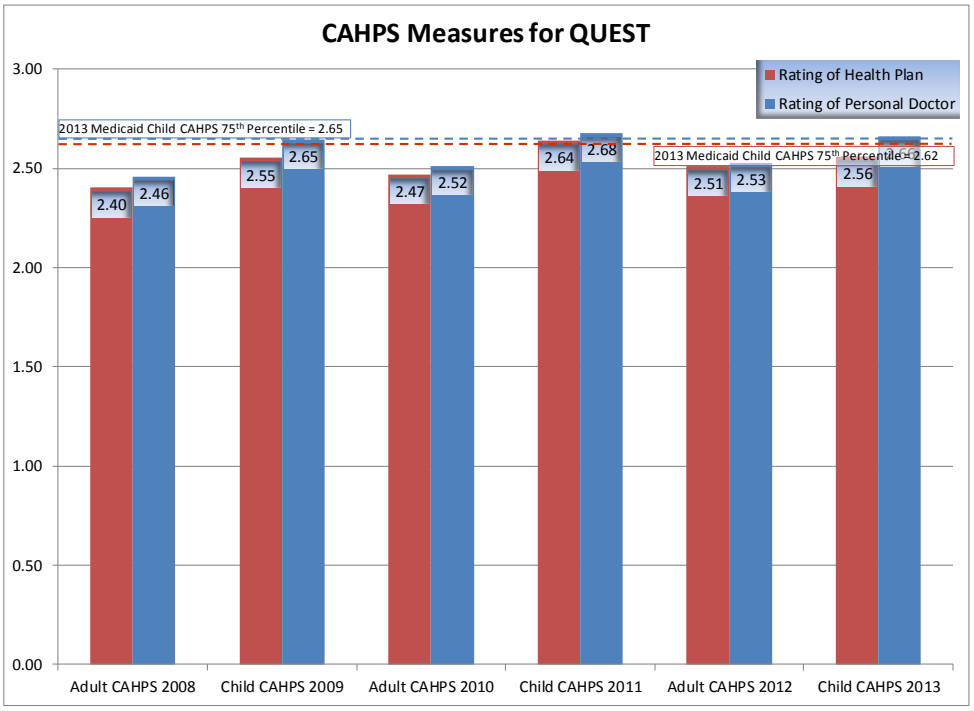
Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures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

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

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

CAHPS for QUEST – Rating of Health Plan:

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



- There is a clear up trend in the rates of the six years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show more of a bell curve, moving from 2.55 to 2.64 to 2.56.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.62 that was not exceeded by the 2.56 rate reported in 2013.

CAHPS for QUEST – Rating of Personal Doctor:

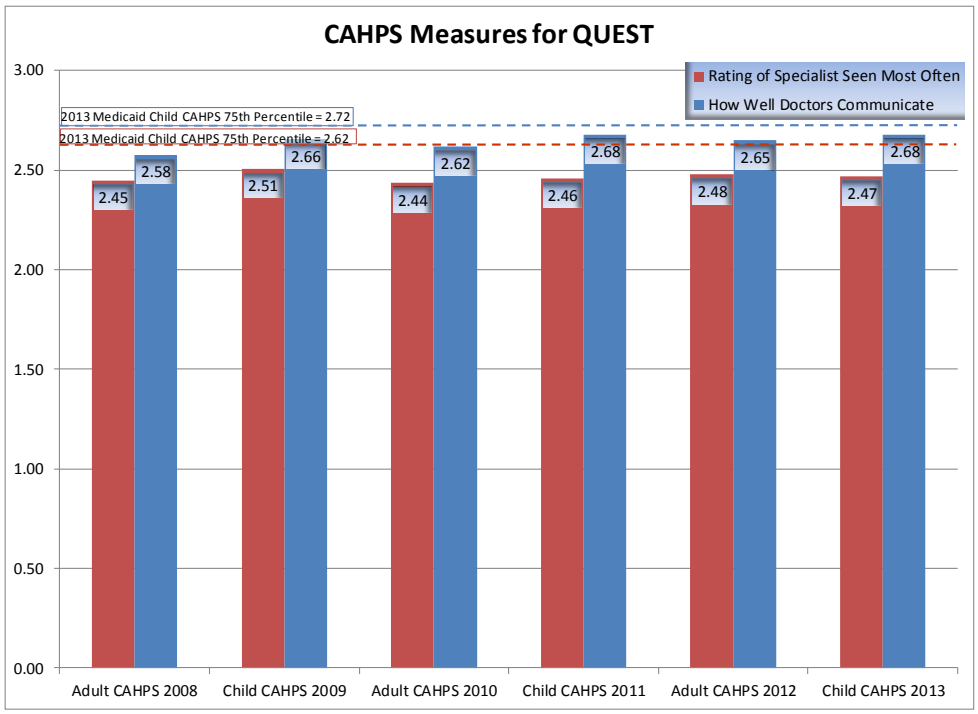
- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear up trend in the rates for the six years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a slight downward trend, moving from 2.65 to 2.68 to 2.62.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.65, which was slightly missed by the 2.62 rate reported in 2013.

CAHPS for QUEST – Rating of Specialist Seen Most Often:

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



  - There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46 to 2.47.

  - The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.62 that was higher than all of the reported year.

  - Improving the QUEST scores for CAHPS – Rating of Specialist Seen Most Often have involved: 1) Emphasizing telemedicine as an option for neighbor island clients seeking specialist services, 2) Increasing the frequency of specialists visits to neighbor islands, and 3) Implementing communication programs for physicians focused on skill building in the area of dealing with challenging situations.

CAHPS for QUEST – How Well Doctors Communicate:

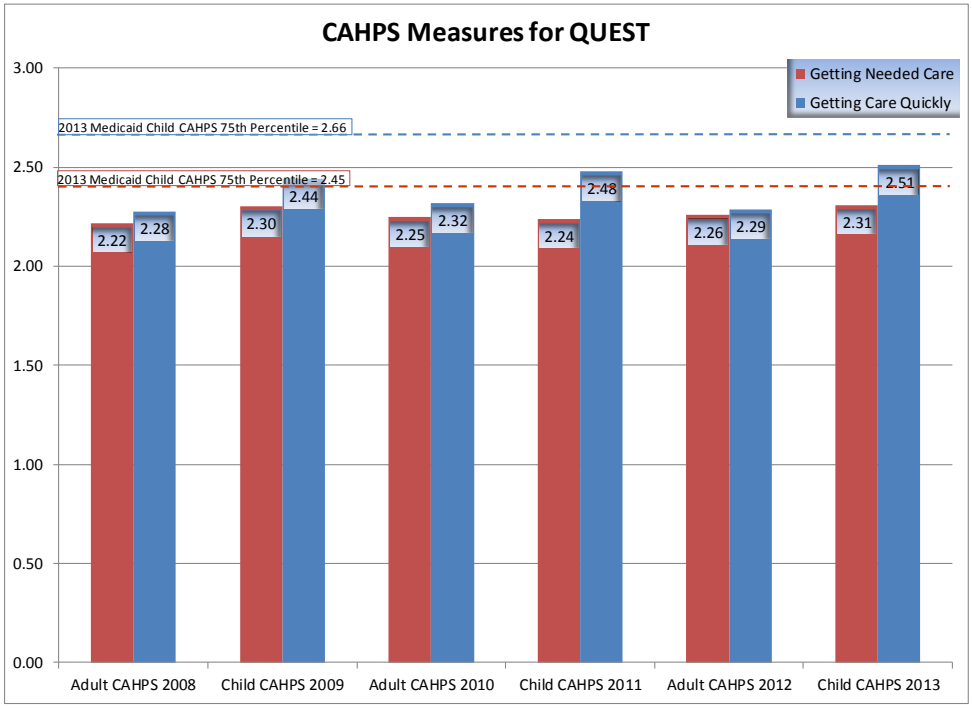
- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.68 occurring in 2011 and 2013 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the six years reported. Focusing on the Adult years, the rates move from 2.58 to 2.62 to 2.65. The Child years show a similar pattern, moving from 2.66 to 2.68 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.72 that was higher than all of the reported year.

- The QUEST plans have taken the following step to improve the CAHPS – How Well Doctors Communicate rates: 1) Improving the care coordination and communication between member and the primary care team.

CAHPS for QUEST – Getting Needed Care:



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

- There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern with a return to a higher rate in 2013, moving from 2.30 to 2.24 to 2.31.

- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.45 that was higher than all of the reported year.

CAHPS for QUEST – Getting Care Quickly:

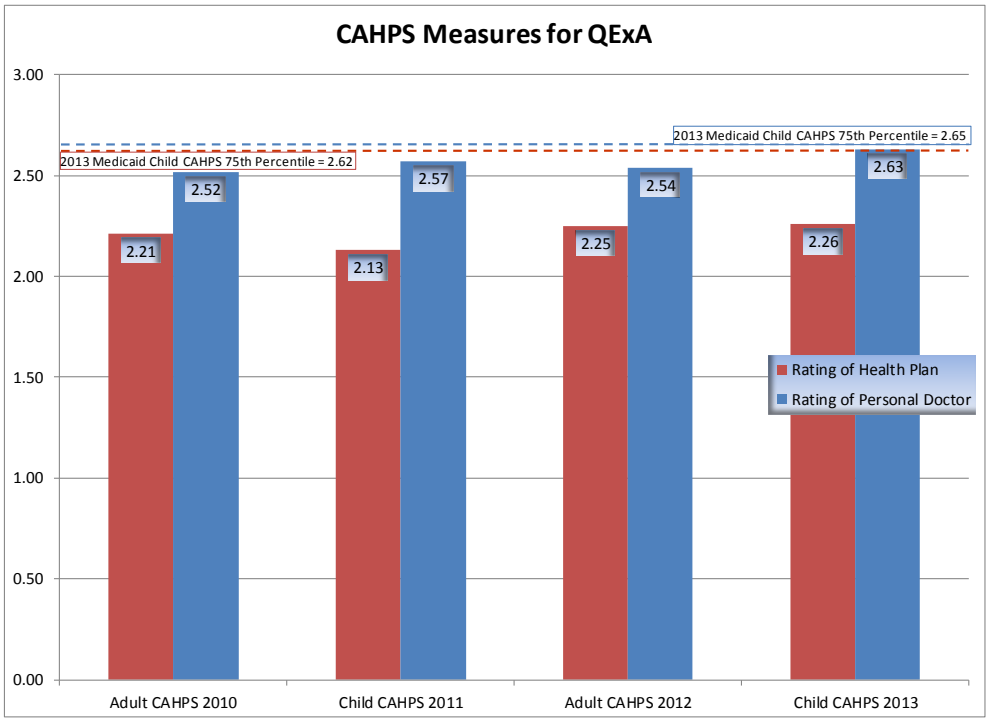
- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.51 occurring in 2013 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the six years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48 to 2.51.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.66 that was higher than all of the reported year

CAHPS for QExA – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.26 occurring in 2013 and the lowest rate of 2.13 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child. Also note that the QExA program began in February 2009, which limits the number of data points.



- There is a flat trend in the rates of the four years reported. The low point in 2011 (2.13) was the first data point for the Child population. The data for the Child population has increased in 2013 to 2.26.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2013 year this target was 2.62 that was better than all reported rates.

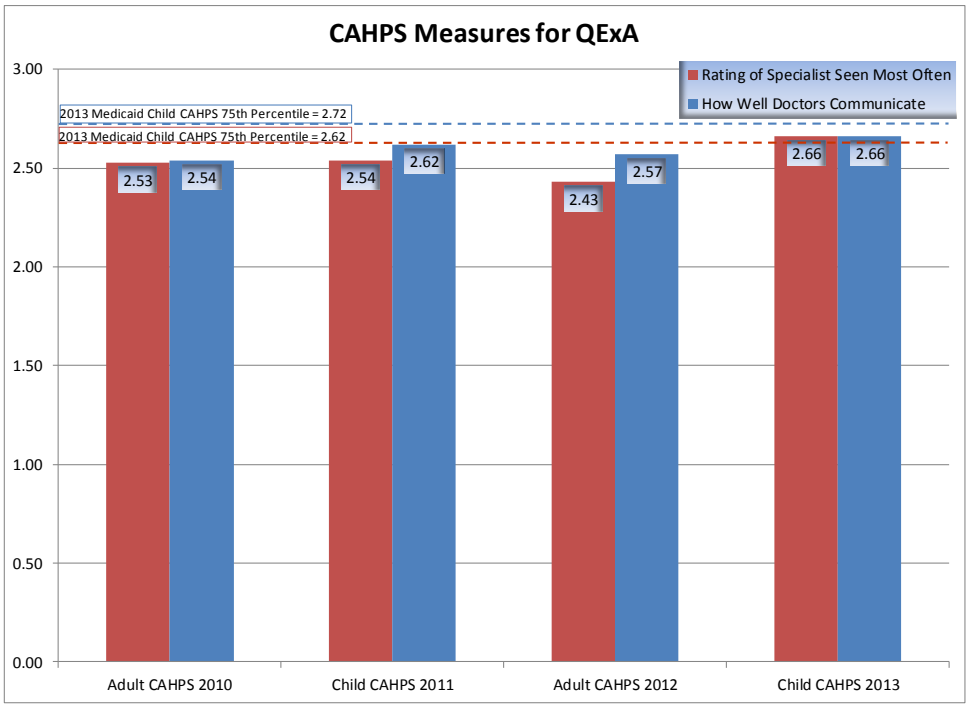
CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.63 occurring in 2013 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the first four years reported. The first three years lie within a 0.05 point window. However, in 2013, the rating has increased to 2.63 that is 0.6 points over the previous Child survey.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.65 that is higher than all of the reported years' rates.

CAHPS for QExA – Rating of Specialist Seen Most Often:



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

- The trend in the past year (2013) has increased over the previous four years.

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

CAHPS for QExA – How Well Doctors Communicate:

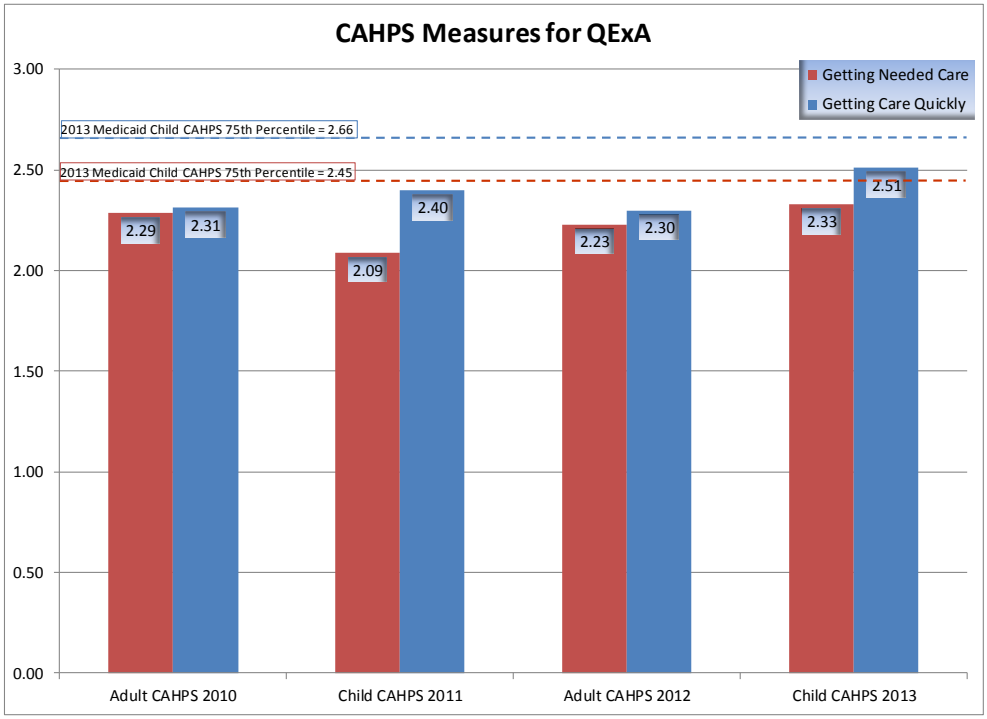
- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.66 occurring in 2013 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- The trend in the four years reported is slightly increased. The Adult score moves from 2.54 to 2.57 from 2010 to 2012; the Child score moved from 2.62 to 2.66 from 2011 to 2013.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.72 that is higher than all of the reported year.

CAHPS for QExA – Getting Needed Care:

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



- There is no clear trend in the Adult rates of 2010 and 2012; however, the Child rate is trending positively from 2011 to 2013 (from 2.09 to 2.33).

- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.45 that is above each of the reported years.

CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.51 occurring in 2013 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.

- The Adult rates remained consistent from 2010 to 2012; the Child rates increased from 2.40 to 2.51 from 2011 to 2013.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2013 year -- the latest year with national averages -- this target was 2.66 that is higher than all of the reported year.

Physicians' Assessment Measures

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

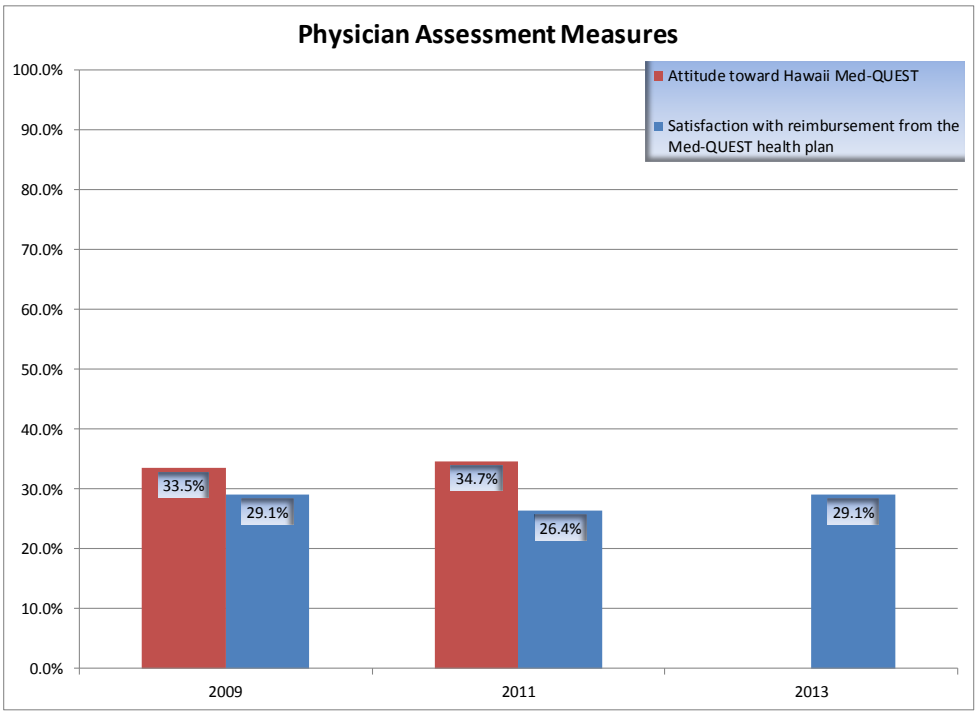
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall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

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

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

Physician Assessment – Attitude Toward Hawaii Med-QUEST:

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



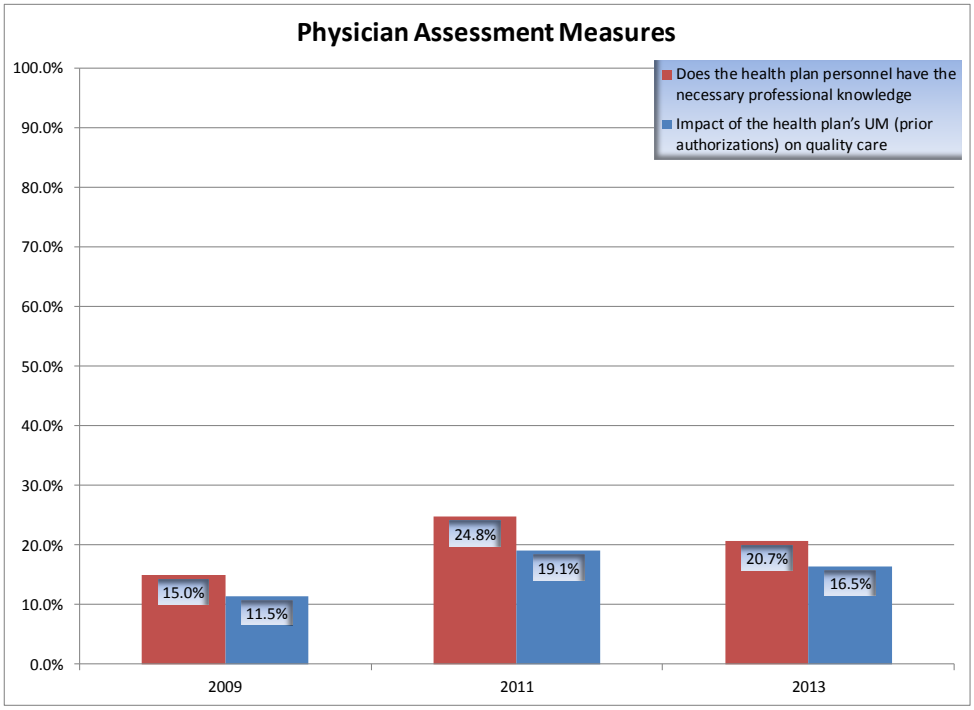
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.
- There are no results for 2013.

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

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

Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% in 2011 and down to 20.7% in 2013.
- With only three data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.



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

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

Med-QUEST Internal Measures

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

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

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

Recent Initiatives on Measures

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

HEDIS Initiatives

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

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

Comprehensive Diabetes Care (CDC) Initiatives:

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

- One health plan reported that diabetes education classes are still available to all individuals at-risk of developing diabetes and individual with diabetes. PCP teams refer members to these classes to receive education about diabetes, including teaching about diet, exercise, medications, and labs, among other topics. These are taught by health educators, dietitians, and nurses. More recently, the diabetes classes are also teaching self-monitoring with glucometers and insulin starts if needed. Nurses continue to be available to the PCP team to provide urgent teaching for glucometers and insulin starts.

- Implemented reminder systems to inform diabetics of needed preventive services and to contact non-compliant members using letters and/or calls. Several health plans also inform providers of members who were overdue for preventive visits and screenings.

- Provide outreach to diabetics by identifying new diabetic members in a new welcome call assessment. One health plan also sends a letter and diabetes member toolkit, called the "ABCs of Diabetes" to all members who were identified as having diabetes. This toolkit included an educational brochure and diabetes checklist for members to use in managing their diabetes.

- One health plan is starting automated batch ordering of labs for members with diabetes every six months. Automated recorded reminders were also started for members with overdue labs, in addition to calls made by an outreach team. These steps gave added assurance that members with diabetes are not overlooked in terms of their routine labs.

- One health plan's outreach team has been focusing on its Medicaid members with diabetes to provide the additional assistance to the PCP team, regardless of whether the member has been referred to the outreach team. In addition to placing reminder calls about labs, the outreach team also assists in titrating medications to get HbA1c and LDL levels to goal. The outreach team has also started to ensure that Medicaid members with diabetes have a three (3) month supply of medications to increase compliance.

- Distributing periodic newsletters with diabetes articles and updates.

- Offer provider training on the importance of tracking Body Mass Index (BMI) of their patients with diabetes as well as offering nutrition and physical activity counseling.

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

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

- One health plan has a team composed of nurses and pharmacists that provides support to individuals with cardiovascular disease. This team helps to contact members who are due for labs and/or medication pick-up and assists PCP teams with titrating medications to bring members to goal.

- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.

- One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.

- One health plan implemented a "Hospital to Home" care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member's understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member's case.

Childhood Immunization Status (CIS) Initiatives:

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.

- Offered provider education and assistance to help bridge gaps in member care and compliance.

- Established patient reminder and recall systems that include postcard and telephone reminders to non-responders for missed appointments and/or immunizations.

    - One health plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.

- Conducted regular assessments of immunization rates.

    - One health plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the 'How Are We Doing Reports' and conducts systems and process improvement recommendations for underperforming clinics.

- Implemented provider incentives and/or a comparison of performance to a goal or standard.

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

- Health plans implemented mechanisms to obtain data from two major laboratory vendors. In addition, physicians are entering immunization data into health plan's quality monitoring system.

- One health plan is matching all laboratory claims data with reports that are given by the laboratory vendors to assure that they are receiving adequate information.

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

- Implemented reminder systems that inform patients of upcoming mammogram, cervical cancer screening appoints and eligible females who have not received a screening for Chlamydia in the recommended time frame.

- Reduced barriers that may be preventing the patient from receiving a mammogram.

    - One health plan reports success with their Mobile Health Vehicle and plans to expand this service in 2012 to include diagnostic breast imaging in addition to screening mammography

    - One health plan is trialing evening outreach for pap appointments and focusing pap clinics in areas with highest screening needs.

- Improved the capture of screenings for members who have been screened.

    - One health plan executed contract amendments with the two main laboratories in Hawaii to assure lab results' supplemental data are obtained for those performance measures which require a result determination.

    - One health plan receives supplemental data from an FQHC that does not submit claims to the health plan for Chlamydia screening. The health plan obtains a list of members who have received a screening as well as a sample of the Electronic Health Records for primary source verification, which is then reviewed by an auditor for compliance. This supplemental data had a positive impact on the 2011 HEDIS rate as there was an increase of 10% in the number of members receiving a Chlamydia test during the measurement year for the QUEST population.

Ambulatory Care (AMB) Initiatives:

- Implemented education of members on appropriate ER use.

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

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

CMS-416 EPSDT Measures Initiatives

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

CAHPS (QUEST & QExA) Initiatives

Rating of Health Plan & Rating of Personal Doctor Initiatives:

- Utilized online and technology assets to outreach to members.
    - One health plan launched a new Health & Wellness section on its website, along with notifying member of this new section.
    - One health plan updated their secure member portal, to add functionality to include ordering and printing ID cards, change PCPs, and update demographic information.
- ***Used face-to-face meetings to assess and evaluate the membership experience with the health plan.***
    - One health plan conducted member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.
    - One health plan conducted quarterly focus groups to gain a better understanding of the member needs, expectations and dissatisfactions.
- ***Utilized "hard copy" media to outreach to the member and increase member satisfaction with the health plans.***
    - One health plan sent out members-specific letters detailing preventive visits and screenings or tests that are coming due, as well as an explanation as to the necessity of these visits.
    - One health plan created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.
- ***Conducted an internal review of information flow to improve health plan responsiveness to member problems.***
    - One health plan recently improved its process to reimburse dual-eligible members for erroneously paid co-pays. Service coordinator and call center staff were re-trained to follow new protocols to speed the identification and reimbursement to the member. Provider education was provided on appropriate billing for dual-eligible members to prevent this from occurring in the first place.

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

- Utilized online and technology assets to outreach to provider to improve care delivery.
    - One health plan made available members' HEDIS care gaps to providers via secure online content. Providers could then close these recommended care gaps with their members.

- Incentivized providers to improve care.
    - One health plan offered $100 per member incentives to providers to complete care gaps for dual eligible members.

Getting Needed Care & Getting Care Quickly Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.
    - One health plan streamlined the provider search functionality on their website.
    - One health plan increased the update frequency of the online provider directories to daily.
    - One health plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.
    - One health plan added online 'enter' and 'view' functionality for prior authorizations, admissions and referrals
- Reached out to members to gauge provider access and care delivery.
    - One health plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.
    - One health plan conducted ongoing member surveys to further gauge timely access to care.
- Personally assisted members with obtaining needed provider appointments.
    - One health plan coordinated the scheduling of appointments for "hard to find" specialists such as Neurosurgeons, Pulmonologists, Gastroenterologists, etc. when the member was having a difficult time doing this on their own.
    - One health plan encouraged open access scheduling models at physician offices, where part of the physician's schedule is left open for same-day patient access or urgent visit reservations.
    - One health plan merged systems that track gaps in HEDIS-related care with customer service, so that during member calls the customer service rep can reminder the member that they need to see a provider and even offer to set up an appointment.
    - One health plan implemented a Complex Case Management program to assist members that have experienced a critical event or diagnoses that requires extensive use of resources. This program provides a comprehensive assessment of the member's condition, development and implementation of a care plan, and monitoring and follow-up with the member's PCP.
- ***Other miscellaneous improvements were made.***
    - All of the health plans simplified the drug prior authorization process by standardizing the form across all Medicaid members.

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

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

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

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

- One health plan began implementation of Patient-Centered Medical Homes in key FQHCs. A data analyst and care advocate works with the FQHC to provide data on care opportunities, and to assist with coordination of care related to these opportunities.

- One health plan expanded their use of telemedicine. Though this health plan continues to send Oahu specialists to other islands, telemedicine has proven especially useful for members on other islands by reducing the need for travel to Oahu. This has also resulted in increased member satisfaction of specialty care and access for member health care.

Physicians' Assessment Initiatives

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

- Utilized online and technology assets to improve the ability of members to connect to providers.

    - One plan created a centralized email inbox to streamline provider inquiries to the health plan's provider relations department, including reimbursement and claim issues.

- Created internal advocacy for provider needs and interests.

    - One health plan started a Provider Advisory Group within the Health Plan to take the provider's point of view, and to review new provider forms and programs.

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

- Improved the knowledge base of their employees through various training modalities.

    - One health plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.

    - One health plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.

    - One health plan increased staff coaching and mentoring activities.

- One health plan conducted monthly knowledge quizzes to gauge whether additional training is needed.

- Initiated improvements to the prior authorization process.
    - One health plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
    - One health plan added an online PA application to streamline the PA process.
    - One health plan increased provider training and education related to the online PA process.
    - One health plan distributed handouts on the PA process during periodic provider relations visits.
    - One health plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
    - One health plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
    - One health plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

Plan All-Cause Readmission Initiatives

- One health plan implemented the Hospital Utilization Readmission Reduction Team (HURRT), that includes an interdisciplinary team of clinical staff (medical, social work, and behavioral health), managers, and medical directors (medical and behavioral health) to review the "super utilizers" (i.e., top 1 percent of utilizers, complex medical/behavioral health cases). Case reviews are presented on the members most frequently readmitted to the hospital and/or with the highest ER usage and provide a comprehensive recommendation to the specific service coordinator/case manager to incorporate in the member's care plan. This health plan reports that it has seen a decrease in readmission rates for those members who had interventions through this interdisciplinary team.

- One health plan implemented a new 30-day hospital readmission program called AHOP (After Hospital Outreach Program) targeting members with congestive heart failure to help prevent hospital readmissions. Interventions include health education, follow-up appointments, transportation, and collaboration with PCP.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
    - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to "get into a waiver."

- Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
- Choices offered include:
  - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
  - Residential settings such as community care foster family homes or assisted living facilities
  - Institutional setting
- Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
- DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation

- Standardized assessment tools for HCBS
  - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
  - The use of these assessment tools have helped to streamline receipt of services

Hawaii Medicaid Enrollment Initiatives

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

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 2013, MQD moved into the first 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 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:

- Member Rights and Protections and Member Information
- Member Grievance System
- Access and Availability
- Coverage and Authorization
- Coordination and Continuity to Care

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 performed Performance/HEDIS validation reports as well as PIP reports. In regards to the PIPs, in 2013, 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 Child 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 19, 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 year 20. Prior to any health plan report tool being issued, MQD receives input from the QUEST and QExA health plans. MQD has templates implemented for all reports submitted.

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 19.

Financial/Budget Neutrality Development/Issues

The MQD submitted budget neutrality for each quarter in demonstration year 19.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	July to September 2012 (1st qtr)	October to December 2012 (2nd qtr)	January to March 2013 (3rd qtr)	April to June 2013 (4th qtr)
Aged	60,626	61,849	62,424	62,866
Blind/Disabled	73,057	72,993	73,181	73,306
Children (EG1)	416,246	428,906	426,706	429,548
Adults (EG2)	290,526	304,210	303,985	306,471

B. For Informational Purposes Only

With Waiver Eligibility Group	July to September 2012 (1st qtr)	October to December 2012 (2nd qtr)	January to March 2013 (3rd qtr)	April to June 2013 (4th qtr)
MQD Plan Adults	114,367	116,088	114,505	114,361
MQD Plan Children	323,325	329,900	325,502	328,679
Optional MQD Plan Children				
Optional MQD Plan Children MCHP	82,671	88,052	90,378	90,224
CHIPRA	10,154	10,872	10,696	10,503
Foster Care Children	96	82	130	142
Medically Needy Adults				
Demonstration Eligible Adults (QUEST & QUEST-Net Adults)	136,164	128,194	116,885	105,888
Demonstration Eligible Adults (QUEST-ACE)	39,995	59,928	72,595	86,222
Aged with Medicare	56,398	57,463	57,841	58,213
Aged without Medicare	4,228	4,386	4,583	4,653

With Waiver Eligibility Group	July to September 2012 (1st qtr)	October to December 2012 (2nd qtr)	January to March 2013 (3rd qtr)	April to June 2013 (4th qtr)
Blind/Disabled with Medicare	29,482	30,051	30,157	30,602
Blind/Disabled without Medicare	43,472	42,857	42,942	42,627
Breast and Cervical	103	85	82	77

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 19.

QUEST Consumer Issues

During the demonstration year 19, the HCSB/QMRI, as well as other MQD staff, processed approximately 18 member and provider telephone calls and e-mails (see table to below) for the QUEST program.

	Member/Provider
3rd qtr 2012	1
4th qtr 2012	5
1st qtr 2013	5
2nd qtr 2013	7
Total	18

These numbers are not distinct members or provider, but are distinct issues. The number of calls from members and providers is half that in SFY13. 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. Despite communication during SFY2013, HCSB/QMRI has not seen a larger number of consumers contact us regarding the QUEST program.

QExA Consumer Issues

During the demonstration year 19, the HCSB/QMRI staff, as well as other MQD staff, processed approximately 152 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% than from the start of QExA when the HCSB received approximately 73 member calls in the first quarter of 2009.

	Member	Provider
3rd qtr 2012	49	8
4th qtr 2012	25	8
1st qtr 2013	24	2
2nd qtr 2013	21	15
Total	119	33

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 240 calls per month (on average) during the fourth year of the program (see Attachment D for Fourth Year Ombudsman program report). The Fifth Year of the QExA Ombudsman report is attached as Attachment E.

Calls to QExA Ombudsman Program		
	# of calls	Distinct Callers
3rd qtr 2012	259	184
4th qtr 2012	270	222
1st qtr 2013	214	174
2nd qtr 2013	215	189
Total- average	240	192

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 19, the HCSB/MPRS, as well as other MQD staff, processed approximately 69 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 2012	21
4th qtr 2012	10
1st qtr 2013	20
2nd qtr 2013	18
Total	69

Appeals

During the demonstration year 19, the HCSB processed 18 appeals (see table to below). All of these appeals were appealing the health plans decision to reduce or deny services. In these appeals,

	Appeals
3rd qtr 2012	5
4th qtr 2012	4
1st qtr 2013	4
2nd qtr 2013	5
Total	18

the hearing officer felt that the actions taken by the health plan were not appropriate (i.e., the appeal was overturned) in 0 of the 18 appeals (0%). The hearing officer felt that the actions taken by the health plan were appropriate (i.e., the appeal was upheld) in 4 of the 18 appeals (22.2%). One (1) beneficiary did not show for their hearing, so this appeal was upheld. In addition, 13 of the 18 appeals through administrative resolution were withdrawn or dismissed because MQD did not agree with the health plan's denial or reduction. In these situations, through MQD's intervention, the beneficiaries received the services that they had submitted the appeal for initially. Administrative resolution was approximately 72.2% of the appeals.

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.

The MQD underwent an audit from CMS in June 2013 on its Program Integrity (PI) processes. Several areas for deficiency were noted in areas of managed care. See link below to CMS audit.

http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Program-Integrity-Review-Reports-List.html#

Lawsuits

One member filed a lawsuit in circuit court related to health plan's processing of denial of services. The DHS has prevailed in this lawsuit in 2014. The lawsuit has been appealed to the Hawaii Supreme Court for review.

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. The limited benefit package was eliminated on July 1, 2012 causing an increase in this population. Based on QUEST-ACE enrollment of approximately 28,750 at the end of demonstration year 19, 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 2012 compilation of the QExA Dashboard is attached as Attachment F and the 2013 version of the QExA Dashboard is attached as Attachment G.

The number of member calls for demonstration year 19 is consistent. United continues to receive more member calls on average than ‘Ohana. On average, over demonstration year 19, ‘Ohana received approximately 5,457 and United received approximately 5,619 member calls per month (see table to the right). This is a decrease from the first year of QExA implementation for ‘Ohana they were receiving approximately 6,854 member calls per month.

# of member calls received		
Monthly	‘Ohana	United
Start of QExA	6,854	5,665
3rd qtr 2011	5,677	5,590
4th qtr 2011	5,374	5,518
1st qtr 2012	5,524	5,653
2nd qtr 2012	5,251	5,714
Total- av	**5,457**	**5,619**

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

United has less provider calls than ‘Ohana in demonstration year 19. Both ‘Ohana and United have maintained approximately that same number of provider calls over demonstration year 19 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	6,666	3,711
3rd qtr 2011	4,965	2,427
4th qtr 2011	4,486	2,303
1st qtr 2012	4,344	2,170
2nd qtr 2012	4,532	2,196
Total- av	**4,582**	**2,274**

Annual Plan Change

QExA Annual Plan Change (APC) was in November 2013 to coordinate with new MIPAA requirements. 547 members changed health plans during APC. 289 individuals left ‘Ohana and 258 left United.

Annual Plan Change for QExA- Nov 2012	
	# of health plan changes (loss to plan)
‘Ohana	289
United	258
Total	547

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 2013, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 2nd Qtr 2013
HCBS	2,110	4,703	122.9%↑	42.6%	67.1%↑
NF	2,840	2,301	19.0%↓	57.4%	32.9%↓
Total	4,950	7,004	41.5%↑		

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 final demonstration evaluation to CMS on January 24, 2014 during Demonstration Year 20.

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Tables

Table 1- Enrollment Counts

	June 2012	June 2013	Percent Change
By Program			
QUEST			
1925- Transitional Medicaid	6,361	6,558	3.1%
Adult/Children AFDC Family members covered by Section 1931	85,674	87,993	2.7%
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	5,208	5,020	(3.6 %)
General Assistance	5,292	5,497	3.9 %
QUEST-Net	1,015	11,833	1065.8 %
QUEST	74,354	49,758	(33.1 %)
QUEST-ACE	13,845	26,525	91.6 %
S-CHIP	27,340	28,890	5.7 %
TANF	15,129	15,198	0.5 %
QUEST Total	**234,218**	**237,272**	**1.3 %**
QUEST Expanded Access (QExA)			
Aged, Blind, Disabled (ABD)	42,665	43,577	2.1 %
QExA Spenddown	2,375	2,415	1.7 %
Other (QMB, SLMB, QDWI)	3,781	4,091	8.2 %
QExA and other ABD Total	**48,821**	**50,083**	**2.6 %**
BHH (Basic Health Hawaii)/ QUEST State Funded	4,863	5,055	4.3 %
QUEST/QExA/Other Total	**287,902**	**292,423**	**1.6 %**
Health Plan			
AlohaCare	81,752	69,690	(14.8 %)
HMSA	126,292	130,918	5.3%
Kaiser	27,968	23,167	3.7%
‘Ohana QUEST*	0	9,581	100%
United QUEST*	0	8,892	100%
QUEST FFS Window	3,069	92	(97.0 %)
QUEST Total	**239,081**	**242,340**	**6.1%**
‘Ohana QExA	23,858	24,572	3.0 %
United QExA	21,109	21,364	1.2 %
QExA Total	**44,967**	**45,946**	**2.2 %**
Island			
Oahu	177,258	179,227	1.1 %
Kauai	16,337	16,072	(1.6 %)
Hawaii	60,925	62,145	2.0 %
Maui	29,473	30,951	5.0 %
Molokai	3,213	3,305	2.9 %
Lanai	696	723	3.9 %
Total	**287,902**	**292,423**	**1.6 %**

* New health plan as of July 1, 2012.

Table 2- Benefits for QUEST and QExA

	QUEST	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
Family planning services	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	X
Maternity services	X	X
Medical services related to dental needs	X	X
Other practitioner services;	X	X
Outpatient hospital services	X	X
Personal assistance services - Level I		X
Physician services	X	X
Prescription drugs	X	X
Preventive services	X	X
Radiology/laboratory/other diagnostic services	X	X
Rehabilitation services	X	X
Smoking Cessation	X	X
Sterilizations and hysterectomies	X	X
Transportation services	X	X
Urgent care services	X	X
Vision and hearing services	X	X
Inpatient psychiatric hospitalizations	X	X
Ambulatory mental health services and crisis management	X	X
Medications and medication management	X	X
Psychiatric or psychological evaluation and treatment	X	X
Medically necessary alcohol and chemical dependency services	X	X
Methadone management services	X	X
Intensive Care Coordination/Case Management	X	
Partial hospitalization or intensive outpatient hospitalization	X	
Psychosocial Rehabilitation	X	
Therapeutic Living Supports	X	

	QUEST	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

Attachments
A-F

Attachment A

HEDIS 2013

			HYBRID or ADMIN
I	**Effectiveness of Care**		
	Adult BMI Assessment *(NEW)*	ABA	H
*	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for Nutrition	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
*	Chlamydia Screening in Women	CHL	A
	Appropriate Testing for Children With Pharyngitis	CWP	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Cholesterol Management for Patients with Cardiovascular Conditions	CMC	H
*	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	LDL-C Screening Performed		H
*	LDL-C Screening Level < 100 mg/dL		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 80		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Use of Imaging Studies for Low Back Pain	LBP	A
	Antidepressant Medication Management	AMM	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventitive/Ambulatory Health Services	AAP	A
	Childrens' & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Prenatal		
	Postpartum		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

Will be validated by EQRO.
* P4P 2013

HEDIS 2013

			HYBRID or ADMIN
I	**Effectiveness of Care**		
	Adult BMI Assessment (NEW)	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for Nutrition	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Appropriate Testing for Children With Pharyngitis	CWP	A
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Cholesterol Management for Patients with Cardiovascular Conditions	CMC	H
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	LDL-C Screening Performed		H
	LDL-C Screening Level < 100 mg/dL		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 80		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Use of Imaging Studies for Low Back Pain	LBP	A
	Antidepressant Medication Management	AMM	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventitive/Ambulatory Health Services	AAP	A
	Childrens' & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Prenatal		
	Postpartum		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

Will be validated by EQRO.

HSAG HEALTH SERVICES ADVISORY GROUP

2013 Hawaii CAHPS® QUEST Star Report

Hawaii Child Medicaid CAHPS 2013 Results – QUEST

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to QUEST members.[1,2] Survey participants included child Medicaid members who were 17 years of age or younger and enrolled in a QUEST health plan from July 1, 2012 through December 31, 2012. The following health plan satisfaction ratings are based on the responses of 2,214 parent/caretakers who completed the survey on behalf of a child member.[3] It is important to note that in calendar year 2013 both 'Ohana Health Plan ('Ohana) and UnitedHealthcare Community Plan (UHC CP) QUEST were surveyed for the first time. The 2013 CAHPS results presented in this report represent an initial **baseline** assessment of parents'/caretakers' satisfaction with their child's 'Ohana or UHC CP QUEST health plan; therefore, caution should be exercised when interpreting these results.

Table 1
Overall Member Satisfaction Ratings for QUEST Health Plans

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QUEST Health Plan					
AlohaCare QUEST	★★	★★★	★	★	★
Hawaii Medical Service Association QUEST	★★★	★★★★	★	★★	★★
Kaiser Permanente Hawaii QUEST	★★★★★	★★★★★	★★★★	★★★	★★
'Ohana Health Plan QUEST	★	★+	★+	★+	★+
UnitedHealthcare Community Plan QUEST	★	★+	★+	★+	★+

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 2,214 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. QUEST health plans were compared to NCQA's 2013 HEDIS Benchmarks and Thresholds for Accreditation.

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] AlohaCare's, Hawaii Medical Service Association's, Kaiser Permanente Hawaii's, 'Ohana Health Plan's, and UnitedHealthcare Community Plan's QUEST ratings are based on the responses of 507, 719, 685, 138, and 165 parents/caretakers who completed a survey on behalf of their child member, respectively.

Table 2 Average Ratings and Composite Scores for QUEST Health Plans					
	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QUEST Health Plan					
AlohaCare QUEST	2.53	2.64	2.37	2.24	2.44
Hawaii Medical Service Association QUEST	2.61	2.65	2.39	2.35	2.56
Kaiser Permanente Hawaii QUEST	2.67	2.75	2.53	2.42	2.58
'Ohana Health Plan QUEST	2.16	2.49+	1.98+	2.04+	2.33+
UnitedHealthcare Community Plan QUEST	2.21	2.46+	2.21+	2.09+	2.32+

Note: Based on scores of 2,214 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. Scores were calculated using the method prescribed by NCQA.

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Health plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3 Crosswalk of Average Scores to Stars				
Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Customer Service	2.58	2.51	2.46	2.40
Getting Needed Care	2.50	2.45	2.36	2.29
Getting Care Quickly	2.69	2.66	2.61	2.54

Note: Source of star benchmarks: National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013.* Washington, DC: NCQA, March 15, 2013.

HSAG HEALTH SERVICES ADVISORY GROUP

2013 Hawaii CAHPS® QExA Star Report

Hawaii Child Medicaid CAHPS 2013 Results – QExA

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to QUEST Expanded Access (QExA) members.[1,2] Survey participants included child Medicaid members who were 17 years of age or younger and enrolled in a QExA health plan from July 1, 2012 through December 31, 2012. The following health plan satisfaction ratings are based on the responses of 758 parents/caretakers who completed the survey on behalf of a child member.[3]

Table 1
Overall Member Satisfaction Ratings for QExA Health Plans

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QExA Health Plan					
‘Ohana Health Plan QExA	★	★★	★	★★	★
UnitedHealthcare Community Plan QExA	★	★★★★	★	★★★	★

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 758 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. QExA health plans were compared to NCQA’s 2013 HEDIS Benchmarks and Thresholds for Accreditation.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] ‘Ohana Health Plan’s and UnitedHealthcare Community Plan’s QExA ratings are based on the responses of 500 and 258 parent/caretakers who completed a survey on behalf of their child member, respectively.

Table 2 Average Ratings and Composite Scores for QExA Health Plans					
	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
QExA Health Plan					
'Ohana Health Plan QExA	2.24	2.61	2.28	2.31	2.52
UnitedHealthcare Community Plan QExA	2.32	2.66	2.25	2.36	2.50
Note: *Based on scores of 758 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. Scores were calculated using the method prescribed by NCQA.*					

Health plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3 Crosswalk of Average Scores to Stars				
Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Customer Service	2.58	2.51	2.46	2.40
Getting Needed Care	2.50	2.45	2.36	2.29
Getting Care Quickly	2.69	2.66	2.61	2.54
Note: *Source of star benchmarks:* National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013.* Washington, DC: NCQA, March 15, 2013.				

HSAG HEALTH SERVICES ADVISORY GROUP

2013 Hawaii CAHPS® CHIP Star Report

Hawaii Child Medicaid CAHPS 2013 Results – CHIP

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Medicaid Health Plan Survey was administered by Health Services Advisory Group, Inc. (HSAG), a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) Survey Vendor, to Hawaii's Children's Health Insurance Program (CHIP) members.[1,2] Survey participants included child Medicaid members who were 17 years of age or younger and enrolled in CHIP from July 1, 2012 through December 31, 2012. The following program satisfaction ratings are based on the responses of 876 parents/caretakers who completed the survey on behalf of a child member. It is important to note that in calendar year 2013 the CHIP population was surveyed for the first time. The 2013 CAHPS results presented in this report represent an initial **baseline** assessment of parents'/caretakers' satisfaction with CHIP; therefore, caution should be exercised when interpreting these results.

Table 1
Overall Member Satisfaction Ratings for CHIP

	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
CHIP	★★★	★★★★	★★	★★★	★

What do the stars represent?

Best	Very Good	Good	Fair	Poor
★★★★★	★★★★	★★★	★★	★

Note: Based on scores of 876 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. The CHIP population was compared to NCQA's 2013 HEDIS Benchmarks and Thresholds for Accreditation.[3]

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 2 Average Ratings and Composite Scores for CHIP					
	How Members Rated				
	Health Plan	Personal Doctor	Customer Service	Getting Needed Care	Getting Care Quickly
CHIP	2.59	2.65	2.43	2.36	2.53
Note: *Based on scores of 876 parents/caretakers who completed the CAHPS 5.0H Child Medicaid Health Plan Survey between March and May 2013 on behalf of their child member. Scores were calculated using the method prescribed by NCQA.*					

Ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure evaluated using the following percentile distributions:

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

Table 3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each comparable CAHPS measure.

Table 3 Crosswalk of Average Scores to Stars				
Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Customer Service	2.58	2.51	2.46	2.40
Getting Needed Care	2.50	2.45	2.36	2.29
Getting Care Quickly	2.69	2.66	2.61	2.54
Note: *Source of star benchmarks:* National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013.* Washington, DC: NCQA, March 15, 2013.				

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

HILO PA'A
Family to Family Health Information Center

Ombudsman Status Report

February 1, 2012 – January 31, 2013
QExA – Year 4 Q4

Statistics

Total Calls Y4: 762 **Total Calls Cumulative (Y1- Y3): 4,131**

Total Distinct Callers: 577 **Total Callers Cumulative (Y1- Y3): 2,906**

Percent of calls from Neighbor Islands: 30% **O'ahu: 70%**

Month	Number of Calls	Total Time of Calls (minutes)	Average Length of Call (minutes)	Distinct Callers	Fax	Email	Web Form	Viewed Page	Viewed Page Directly
Year 1 MonAve	181	629	3.2	121	0	1	1	35	17
Y2 MonAve	67	261	3.4	44	0	0	0	22	10
Y3 MonAve	64	169	2.6	50	0	0	0	26	11
February	55	214	3.3	43	0	0	0	28	15
March	49	151	2.6	38	0	0	0	36	16
April	73	256	4.7	70	0	0	0	42	21
May	82	280	3.4	60	0	0	0	35	17
June	80	279	3.1	54	0	0	0	88	27
July*+	122	700	4.6	72	0	1	1	58	32
August	72	233	3.7	60	0	0	0	45	0
September	65	208	3.4	52	0	0	0	49	4
October	103	217	2.2	83	0	0	0	36	1
November	108	286	2.7	89	0	0	0	29	3
December	59	177	2.9	50	0	0	0	16	3
January	71	197	2.8	57	0	0	0	31	14
Total	762	--	--	577	0	2	1	387	101

*single caller calling multiple times a day, +change in website hosting and reporting capabilities

1319 Punahou St., Suite 739 Honolulu, HI 96826 voice (808)791-3467 fax (808)531-3595

HILO PA'A
Family to Family Health Information Center

Ombudsman Status Report

November 1, 2013 – January 31, 2014
QExA – Year 5 Q4

Statistics

Total Calls Y5: 753 **Total Calls Cumulative (Y1- Y4): 5,444**

Total Distinct Callers: 611 **Total Callers Cumulative (Y1- Y4): 3,987**

Percent of calls from Neighbor Islands: 30% **O'ahu: 70%**

Month	Number of Calls	Total Time of Calls (minutes)	Average Length of Call (minutes)	Distinct Callers	Fax	Email	Web Form	Viewed Page	Viewed Page Directly
Y1 MonAve	181	629	3.2	121	0	1	1	35	17
Y2 MonAve	67	261	3.4	44	0	0	0	22	10
Y3 MonAve	64	169	2.6	50	0	0	0	26	11
Y4 MonAve	78	266	3.3	60	0	0	0	41	13
February	79	191	2.4	65	0	0	0	19	1
March	64	144	2.3	58	0	0	0	22	3
April	66	220	3.3	59	0	0	0	23	2
May	54	193	3.7	44	0	0	0	24	8
June	95	355	4.7	86	0	0	0	30	15
July	54	202	3.8	51	0	0	0	26	24
August	50	173	3.2	45	0	0	0	38	12
September	31	100	3.2	31	0	0	0	52	25
October	78	274	3.5	65	0	0	0	26	6
November	59	172	2.9	42	0	0	0	8	1
December	46	142	3.2	28	0	0	0	12	4
January	51	137	2.3	37	0	0	0	13	3
Total	753	--	--	611	0	0	0	293	104

QExA Dashboard Report
Health Plan Comparison
SFY 2013 Monthly Trend Analysis

	July '12		August '12		September '12		October '12		November '12		December '12		January '13		February '13		March '13		April '13		May '13		June '13	
	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	UHC	'Ohana	United	'Ohana	United
# Members																								
Medicaid	10,085	6,605	10,236	6,386	10,262	6,416	9,978	6,566	9,877	6,605	9,867	6,636	9,889	6,615	9,887	6,630	9,868	6,633	9,841	6,686	9,849	6,692	9,759	6,693
Duals	14,617	14,187	14,718	14,097	14,866	14,061	14,872	14,163	14,853	14,239	14,833	14,268	14,658	14,311	14,722	14,414	14,792	14,491	14,875	14,544	14,917	14,598	14,887	14,680
Total Members	**24,702**	**20,792**	**24,954**	**20,483**	**25,128**	**20,477**	**24,850**	**20,729**	**24,730**	**20,844**	**24,700**	**20,904**	**24,547**	**20,926**	**24,609**	**21,044**	**24,660**	**21,124**	**24,716**	**21,230**	**24,766**	**21,290**	**24,646**	**21,373**
# Network Providers																								
PCPs (incl FQHC less est 100 FQHC PCPs)	769	1,073	767	1,084	769	1,087	775	1,112	777	1,120	776	1,124	782	1,149	788	1,161	791	1,167	792	1,190	795	1,194	796	1,201
Specialists	2,020	1,896	2,036	1,911	2,048	1,914	2,053	1,953	2,064	1,963	2,071	1,965	2,092	2,006	2,115	2,017	2,138	2,022	2,145	2,070	2,157	2,076	2,154	2,089
Facilities (Hosp./NF)	62	58	62	58	62	58	62	58	62	58	62	58	62	58	62	58	63	58	63	58	63	58	63	58
Foster Homes (FH) (CCFHH only; no E-ARCH)	876	1,090	873	1,093	864	1,094	860	1,104	861	1,104	861	1,104	880	1,104	890	1,103	885	1,103	897	1,103	907	1,102	922	1,104
HCBS Providers (All LTC, except CCFHH and NF)	153	198	148	203	148	209	146	208	148	212	150	217	165	223	152	240	151	241	152	251	154	252	154	256
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,403	1019	1,401	1039	1,422	1046	1,436	1066	1,454	1091	1,459	1114	1,472	1155	1,489	1164	1,490	1182	1,507	1206	1,531	1212	1,540	1220
Total # of providers	**5,283**	**5,334**	**5,287**	**5,388**	**5,315**	**5,408**	**5,332**	**5,501**	**5,366**	**5,548**	**5,379**	**5,582**	**5,453**	**5,695**	**5,496**	**5,743**	**5,518**	**5,773**	**5,556**	**5,878**	**5,607**	**5,894**	**5,629**	**5,928**
Call Center																								
# Member Calls	5,447	6,467	5,993	5,744	5,330	4,822	6,011	5,988	5,423	5,346	4,689	4,453	6,373	6,167	4,978	5,172	5,220	5,621	5,385	5,934	5,237	5,818	5,133	5,389
Avg. time until phone answered	0:00:23	00:13	0:00:29	00:19	0:00:18	00:07	0:01:46	00:14	0:00:42	00:16	0:00:29	00:12	0:00:47	00:15	0:00:32	00:15	0:00:30	00:15	0:00:15	00:13	0:00:29	00:09	0:00:38	00:11
Avg. time on phone with member	5:12	6:27	4:17	7:51	6:56	7:20	6:25	7:43	5:58	7:21	7:48	7:23	7:47	6:31	8:14	7:18	8:55	7:27	7:51	7:42	8:12	7:31	8:57	6:59
% of member calls abandoned	4%	4.2%	4.0%	3.4%	18.8%	0.7%	12.5%	2.0%	5.1%	3.5%	3.3%	2.6%	6.1%	4.1%	3.7%	5.7%	3.9%	4.3%	1.6%	2.9%	3.4%	2.9%	4.7%	2.6%
# Provider Calls	4,737	2,686	5,209	2,455	4,950	2,139	5,353	2,306	4,255	2,064	3,850	1,885	4,705	2,309	4,090	1,877	4,237	2,323	4,512	2,166	4,730	2,279	4,355	2,142
Avg. time until phone answered	0:00:32	00:15	0:00:55	00:18	0:03:34	00:08	0:05:50	00:14	0:00:58	18:00	0:01:03	00:14	0:01:20	00:16	0:00:55	00:15	0:00:52	00:14	0:00:36	00:11	0:00:58	00:10	0:01:06	00:10
Avg. time on phone with provider	5:22	11:27	5:09	08:23	7:11	07:02	7:40	07:44	7:21	24:00	7:40	07:43	7:52	06:39	8:16	07:26	7:59	08:03	7:04	8:12	7:42	7:48	8:09	7:32
% of provider calls abandoned	3%	3.1%	5.0%	3.0%	19.7%	0.3%	17.2%	1.0%	5.3%	2.2%	6.3%	1.8%	7.0%	2.3%	5.2%	3.1%	4.7%	3.2%	2.5%	2.2%	4.2%	1.3%	5.0%	2.1%
Medical Claims- Electronic																								
# Submitted, not able to get into system	3,048	441	2,857	435	2,435	406	2,820	430	2,455	630	2,498	453	2,560	940	2,275	1,179	2,881	1,140	2,601	641	3,107	941	3,634	1,833
# Received	37,448	26,930	38,072	26,470	36,174	24,894	42,569	30,046	41,027	25,257	43,151	28,636	44,294	31,476	41,449	29,153	48,768	2,840	41,532	27,183	48,103	35,978	6,491	29,873
# Paid	30,197	21,813	31,514	21,282	32,042	19,791	36,034	23,917	32,003	20,332	36,971	22,831	33,827	25,685	33,458	24,022	38,518	23,155	33,181	21,774	32,412	27,307	54,746	23,719
# In Process	8,199	13,508	8,648	7,830	7,880	4,101	9,199	2,991	6,230	4,894	3,982	4,078	4,406	2,456	5,535	3,765	4,244	3,074	2,585	4,680	15,210	8,527	16,723	5,094
# Denied	6,897	5,117	6,450	5,188	6,386	5,103	6,363	6,129	8,894	4,925	10,599	5,805	8,138	5,791	8,552	5,131	9,803	5,295	8,232	5,409	3,481	8,671	22,743	6,154
Avg time for processing claim in days	14.3	23	13	23	13.3	21	12	19	12	19	10	49	8	16	8	16	8		8	15	11	18	14	19
* unable to break out (month to date)																								
Medical Claims- Paper																								
# Submitted, not able to get into system	484	384	464	413	497	362	612	351	465	453	234	318	245	786	219	878	246	798	240	428	278	652	201	1,195
# Received	25,700	23,406	27,167	25,128	21,574	22,164	26,322	24,483	24,521	18,140	21,528	20,148	22,805	26,301	21,813	21,724	22,724	19,934	23,152	18,197	17,584	24,898	8,500	19,480
# Paid	19,492	18,959	19,788	20,203	19,690	17,621	19,277	19,489	19,547	14,603	18,805	16,058	16,075	21,462	14,795	17,901	16,239	16,224	15,907	14,576	12,792	18,898	10,189	15,467
# In Process	8,609	11,740	11,205	7,433	7,981	3,651	8,389	2,438	6,074	1,185	3,229	2,869	2,569	2,053	2,474	2,805	2,440	2,154	2,670	3,132	8,037	5,901	4,950	3,322
# Denied	8,336	4,447	8,738	4,925	7,731	4,543	6,274	4,994	8,516	3,537	7,941	4,090	7,815	4,839	7,502	3,823	7,715	3,710	7,374	3,621	3,076	5,757	4,772	4,013
Avg time for processing claim in days (month-to-date)	19.7	23	18	23	18.4	17	16	15	15	15	12	14	10	12	10	14	10	13	11	18	14	22	22	23
# Non-Emergency Transports																								
Ground	16,110	15,330	17,682	16,022	16,044	14,386	18,416	16,058	17,142	14,650	16,648	14,447	17,696	15,344	16,585	14,325	17,437	15,270	17,860	15,852	18,317	16,177	16,145	14,377
Air	434	335	459	344	468	281	544	332	451	260	407	288	531	289	425	333	483	314	557	354	545	325	492	300
* round trip																								
# Member Complaints																								
# Received	28	81	49	93	38	56	41	43	27	46	45	43	47	47	38	46	46	62	31	62	60	79	38	33
# Resolved	13	46	22	57	18	39	6	35	7	52	17	47	6	46	2	32	9	50	41	62	54	67	41	71
# Outstanding	15	35	27	36	20	17	35	25	20	24	28	20	41	21	36	35	37	47	24	47	30	59	27	21
# Provider Complaints																								
# Received	4	0	1	0	4	0	3	0	2	0	5	0	4	0	1	0	1	0	0	1	5	0	3	0
# Resolved	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	1	4	0
# Outstanding	4	0	0	0	4	0	3	0	2	0	5	0	4	0	1	0	1	0	1	1	4	0	3	0
# Member Appeals																								
# Received	4	6	2	10	2	4	1	5	1	6	3	4	1	2	1	1	0	6	4	1	4	2	6	3
# Resolved	1	4	1	1	2	4	1	1	0	3	0	5	1	4	0	2	0	1	1	4	6	3	1	2
# Outstanding	3	2	1	9	0	0	0	1	1	5	3	4	0	2	1	1	0	6	3	3	1	2	6	3
# Provider Appeals																								
# Received	25	5	87	56	20	71	46	81	49	53	12	64	16	91	22	93	17	38	12	41	20	59	8	43
# Resolved	6	5	35	13	2	36	12	100	12	44	0	30	6	34	1	25	1	41	13	106	14	34	16	49
# Outstanding	19	0	52	43	18	78	34	59	37	68	12	102	10	89	21	89	6	86	39	21	45	46	37	40
Utilization - based on Auth (A) or Claims (C)																								
Inpatient Acute Admits * (A) - per 1,000	263	271	316	252	249	262	233	287	207	213	273	264	276	225	294	199	265	208	209	267	287	265	284	263
Inpatient Acute Days * (A) - per 1,000	988	1,462	1,118	1,433	1,240	1,287	736	1,674	664	1,198	1,053	1,494	997	1,302	848	1,203	772	1,355	725	1,600	932	1,461	1,935	1,511
Readmissions within 30 days* (A)	46	23	58	39	29	32	40	39	32	21	28	20	46	28	35	24	43	26	74	26	52	33	63	48
ER Visits * (C) - per 1,000**	1,035	1,317	1,074	1,285	989	1,221	1,099	1,005	1,063	830	1,041	795	1,156	795	987	688	1,020	751	993	802	1,059	777	1,033	995
# Prescriptions (C) - per 1,000	22,644	20,926	24,209	21,210	22,019	19,629	24,750	21,561	24,072	20,397	23,323	20,020	25,301	21,495	22,319	19,119	24,040	20,272	24,053	20,891	21,132	21,193	20,500	18,350
Waitlisted Days * (A) - per 1,000	233	95	251	160	256	170	366	137	293	257	336	355	374	405	311	268	298	96	309	256	368	348	398	258
NF Admits * (A)	1	0	2	1	1	1	3	0	0	0	1	2	0	1	1	0	2	2	3	0	2	1	3	0
# Members in NF (non-Medicare paid days) (C)**	1,493	1,030	1,478	1,012	1,384	992	1,496	1,031	1,488	986	1,483	951	1,441	921	1,338	927	1,411	901	1,396	890	1,319	881	1,467	1,243
# Members in HCBS **(C)- note: member can be included in more than one category listed below	2,343	2,239	2,172	2,258	2,149	2,237	2,360	2,299	2,386	2,290	2,354	2,344	2,349	2,342	2,270	2,380	2,301	2,426	2,282	2,454	2,206	2,445	2,277	2,555
# Members in FH **(C)	689	946	674	968	643	943	696	988	693	980	690	995	661	1,014	635	1,007	662	1,013	675	1,004	642	1,011	703	1,044
# Members in Self-Direction **(C)	1,006	844	805	846	925	863	949	857	983	861	1,002	879	1,003	883	967	889	943	905	919	911	914	911	880	952
# Members receiving other HCBS **(C)	1,337	800	1,367	809	1,224	790	1,411	786	1,403	777	1,352	782	1,346	773	1,303	820	1,358	852	1,363	888	1,292	870	1,397	915

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

QExA Dashboard Report
Health Plan Comparison
SFY 2013 Monthly Trend Analysis

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. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

* Duplicates included

as of: June-13

'Ohana Health Plan

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	545	57	9	3	72	72	38	796
Specialists	1,729	120	14	0	102	110	79	2,154
Facilities (Hosp./NF)	36	5	2	1	7	4	8	63
Foster Homes (FH) (CCFFH only; no ARCH)	778	39	0	0	9	72	24	922
HCBS Providers (All LTC, except CCFFH and NF)	110	8	2	0	5	21	8	154
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	980	157	18	6	113	142	124	1,540
Totals	**4,178**	**386**	**45**	**10**	**308**	**421**	**281**	**5,629**
# Members by Island								
Members	16,225	2,346	362	73	900	3,370	1,370	24,646
# Members per PCP by Island								
Members per PCP	30	41	40	24	13	47	36	31
Note: RFP requirement is 600 members for every PCP								

UnitedHealthcare

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	1020	106	19	9	119	107	57	1,437
Specialists	2477	214	41	30	281	155	191	3,389
Facilities (Hosp./NF)	60	5	-	-	10	12	8	95
Foster Homes (FH) (CCFFH only; no ARCH)	939	35	-	-	14	97	22	1,107
HCBS Providers (All LTC, except CCFFH and NF)	206	25	1	1	12	28	12	285
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1154	188	22	14	120	139	69	1,706
Totals	**5,856**	**573**	**83**	**54**	**556**	**538**	**359**	**8,019**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	14,117	1,460	-	-	1,237	3,383	1,174	21,371

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	14	14	0	0	10	32	21	15
Note: RFP requirement is 600 members for every PCP								

as of: June-13

'Ohana Health Plan

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	613	155	6	3	26	102	71	**976**
Network (provider look up, access)	47	9	0	2	6	10	8	**82**
Primary Care Physician Assignment or Change	199	19	2	3	6	34	31	**294**
NEMT (inquiry, scheduling) -*monthly repor*t *	187	32	8	2	6	50	20	**3,637**
Authorization/Notification (prior auth status)	93	29	8	2	15	58	25	**230**
Eligibility (general plan eligiblity, change request)	224	27	1	0	6	33	16	**307**
Benefits (coverage inquiry)	167	30	2	1	7	37	22	**266**
Enrollment (ID card request, update member information)	407	61	12	1	18	110	40	**649**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	184	53	2	0	13	51	27	**330**
Billing/Payment/Claims	59	10	3	2	1	16	9	**100**
Appeals	1	0	0	0	0	3	1	**5**
Complaints and Grievances	40	6	1	0	1	5	2	**55**
Other	677	138	23	6	32	129	66	**1071**
Totals	**2,898**	**569**	**68**	**22**	**137**	**638**	**338**	**8,002**

*Calls logged via TMS and are not broken out by island

UnitedHealthcare

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	15	3	0	0	3	3	1	**25**
Network (provider look up, access)	25	3	2	0	12	2	1	**45**
Primary Care Physician Assignment or Change	201	28	3	0	30	59	23	**344**
NEMT (inquiry, scheduling) -*monthly repor*t*	0	0	0	0	0	0	0	**4,971**
Authorization/Notification (prior auth status)	59	18	3	0	16	25	14	**135**
Eligibility (general plan eligiblity, change request)	6	3	0	0	3	2	0	**14**
Benefits (coverage inquiry)	1,225	127	37	0	169	271	74	**1,903**
Enrollment (ID card request, update member information)	399	33	18	0	66	162	71	**749**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	659	76	22	0	116	174	45	**1,092**
Billing/Payment/Claims	1,075	99	31	0	131	152	44	**1,532**
Appeals	2	0	0	0	0	0	1	**3**
Complaints and Grievances	19	5	0	0	0	3	3	**30**
Other	486	69	14	0	72	133	38	**812**
Totals	**4,171**	**464**	**130**	**0**	**618**	**986**	**315**	**11,655**

*Calls logged via Logisticare call center