Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: December 1, 2014

Demonstration/Quarter Reporting Period:
Demonstration Year: 21 (7/1/2014 – 6/30/2015)
Federal Fiscal Quarter: 4/2014 (7/1/2014-9/30/2014)
State Fiscal Quarter: 1/2015 (7/1/2014-9/30/2014)
Calendar Year: 3/2014 (7/1/2014-9/30/2014)

Introduction

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

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

The State's goals in the demonstration are to:

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

Enrollment Information

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

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 7/2014-9/2014	Unduplicated Members 7/2014-9/2014
Mandatory State Plan Groups			
State Plan Children	State Plan Children	334,787	111,847
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	155,852	53,772
Aged	Aged w/Medicare Aged w/o Medicare	67,125	24,307
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	75,009	25,654
Expansion State Adults	Expansion State Adults	111,996	41,832
Newly Eligible Adults	Newly Eligible Adults	117,170	41,502
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	838	310
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults	6	23
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group	-36	113
Total		862,747	299,360

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	633,581
Title XXI funded State Plan	90,720
Title XIX funded Expansion	229,166
Enrollment current as of	9/30/2014

Outreach/Innovative Activities

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

line at its mybenefits.hawaii.gov website.

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

Operational/Policy Developments/Issues

During the fourth quarter of FFY14, the Med-QUEST Division (MQD) continued its oversight of the QUEST program for five health plans: AlohaCare, Health Services Medical Association (HMSA), Kaiser Foundation Health Plan, ‘Ohana Health Plan, and United Healthcare Community Plan. The QUEST program serves approximately 264,000 beneficiaries who are not aged or disabled

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

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

QUEST Integration or QI is a melding of both the QUEST and QExA programs. QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition. In QUEST Integration, health plans will provide a full-range of comprehensive benefits including long-term services and supports. MQD has lowered its ratios for service coordination.

The MQD collaborated with Healthcare Association of Hawaii (HAH) to provide a public forum on Hawaii’s 1115-demonstration waiver. MQD and HAH held the public forum on October 31, 2014 from 10:00 am to 12:00 pm at the Queen’s conference center. The Queen’s conference center is located in downtown Honolulu and has access to video teleconference (VTC) for streaming information to islands other than Oahu that include Kauai, Maui, and Hawaii.

HAH invited their membership that include hospitals, nursing facilities, pharmacies, home health agencies, home care agencies, and durable medical equipment (DME) providers. In addition, home and community based service providers such as community care management agencies (CCMA) and community care foster family homes (CCFFH) and federally qualified health centers (FQHC) attended as well.

The MQD posted a public notice on the DHS website for the "Post Award" public forum to be held concurrently with the "QUEST Integration Update" public forum. The public notice invited other interested parties to attend the public forum with an opportunity to provide meaningful comments and solicit feedback on the implementation and progress of the demonstration project.

The public forum included information and discussion on two topics: MQD’s new eligibility system, KOLEA and QUEST Integration implementation. Attachment A provides the agenda, public notice, and presentations from the public forum.

The MQD took and answered questions on both KOLEA and QUEST Integration implementation. Individuals who were at one of the VTC sites were able to send questions to an e-mail address. The moderator incorporated these questions into one of the three answer sessions that were part of the forum. In addition, the five health plans that will implement QUEST Integration on January 1, 2015 participated on the panel. The health plans were able to answer questions about their organizations processes in January 2015.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for fourth quarter of FFY14 was submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (July 2014)	Month 2 (August 2014)	Month 3 (September 2014)	Total for Quarter Ending 9/2014
EG 1-Children	112,106	112,642	110,877	335,625
EG 2-Adults	51,854	51,593	52,411	155,858
EG 3-Aged	22,486	22,115	22,524	67,125
EG 4-Blind/Disabled	24,915	24,914	25,180	75,009
EG 5-VIII-Like Adults	-7	-24	-5	-36
EG 6-VIII Group Combined	76,790	76,711	75,665	229,166

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (July 2014)	Month 2 (August 2014)	Month 3 (September 2014)	Total for Quarter Ending 9/2014
State Plan Children	111,830	112,370	110,587	334,787
State Plan Adults	51,852	51,584	52,416	155,852
Aged	22,486	22,115	22,524	67,125
Blind or Disabled	24,915	24,914	25,180	75,009
Expansion State Adults	35,726	37,570	38,700	111,996
Newly Eligible Adults	41,064	39,141	36,965	117,170
Optional State Plan Children				
Foster Care Children, 19-20 years old	276	272	290	838
Medically Needy Adults				
Demonstration	2	9	-5	6

With Waiver Eligibility Group	Month 1 (July 2014)	Month 2 (August 2014)	Month 3 (September 2014)	Total for Quarter Ending 9/2014
Eligible Adults				
Demonstration Eligible Children				
VIII-Like Group	-7	-24	-5	-36

QUEST Integration Consumer Issues

HCSB Grievance

During the fourth quarter of FFY14, the HCSB continued to handle incoming calls. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (either QUEST or QExA), transfer those telephone calls to the HCSB. The clerical staff person(s) takes the basic contact information and assigns the call to one of the social workers. MQD tracks all of the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., into a QExA health plan), then the CSB will work with the client to resolve their issue. The CSB did not have any calls related to QExA this quarter.

	Member			Provider		
	QUEST	QExA	FFS	QUEST	QExA	FFS
July 2014	2	13	5	1	1	4
August 2014	2	5	2	0	1	0
September 2014	3	6	0	0	2	6
Total	7	24	7	1	4	10

During the fourth quarter of FFY14, the HCSB staff, as well as other MQD staff, processed approximately 53 member and provider telephone calls and e-mails (see table above). The number of calls from members is consistent with other quarters. In previous quarters, MQD received approximately 59 calls, letters, and e-mails.

HCSB Appeals

The HCSB received six (6) appeals in the fourth quarter of FFY14. Of the six (6) appeals that we received, DHS was able to dismiss four (4) of them by working with the health plan to cover the requested service. The other two (2) appeals were provider appeals that were postponed temporarily to allow resolution prior to going to hearing. The types of appeals were primarily medical (2) with one being LTSS (1) medical and one for transportation.

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

Category	#
Submitted	6
DHS resolved with health plan in member's favor prior to going to hearing	4
Provider appeals-postponed	2
Hearings	
Resolution in DHS favor	0
Resolution in Member's favor	0

Provider Interaction

The MQD and the health plans continue to have two regularly scheduled meetings with providers. One of the meetings is a monthly meeting with the Case Management Agencies. MQD focuses the meetings with these agencies around continually improving and modifying processes within the health plans related to HCBS. In addition, the MQD and health plans meet with the behavioral health provider group

that serves the CCS population. This group focuses on health plan systems and addressing needs of this fragile population.

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

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

Enrollment of individuals

The DHS had a reduction of enrollment of approximately 7,000 members during the fourth quarter of FFY14. Of this group, 45 chose their health plan when they became eligible, 3,139 changed their health plan after being auto-assigned.

In addition, DHS had 136 plan-to-plan changes during the fourth quarter of FFY14. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 11 individuals in the QUEST Expanded Access (QExA) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

	#
Individuals who chose a health plan when they became eligible	45
Individuals who changed their health plan after being auto-assigned	3,139
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	136
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	11

Long-Term Services and Supports (LTSS)

HCBS Waiting List

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

HCBS Expansion and Provider Capacity

During the fourth quarter of FFY14, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of clients requiring long-term services and supports continues to increase. In the fourth quarter of FFY14, the increase is 45.3% since the start of the program receiving long-term services and supports. The number of individuals in nursing facilities decreased this past quarter. HCBS usage has more than doubled since the start of the QExA program. Nursing facility services have decreased by approximately 12.3% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 123% since program inception. At the start of the program clients receiving HCBS was 42.6% of all clients receiving long-term care services. This number has increased to 65% (65.3%) since the start of the program.

	2/1/09	3rd Qtr FFY14, av	4th Qtr FFY14, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 4th Qtr FFY14
HCBS	2,110	4,699	4,705	123%↑	42.6%	65.3%↑
NF	2,840	2,546	2,490	12.3%↓	57.4%	34.7%↓
Total	4,950	7,245	7,195	45.3%↑		

Behavioral Health Programs Administered by the DOH and DHS

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

Program	#
Adult Mental Health Division (AMHD/DOH)	253
Child and Adolescent Mental Health Division (CAMHD/DOH)	984
Community Care Services (CCS/DHS)	5,849

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). CAMHD is providing services to approximately 984 children during the fourth quarter to FFY14.

QUEST Integration transition

The DHS started QUEST Integration transition or readiness review for QUEST Integration health plans on February 1, 2014. Readiness review during the fourth quarter of FFY14 consisted of MQD's review of documents that health plans submitted. MQD utilized its process for tracking, review and return of submissions. In addition, MQD used review tools that aligned contract requirement with deliverables for approval.

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

- DD Road Show (training with QI health plans and Developmental Disabilities Division in Hilo, Maui, and Kauai on ESPDT coordination for children in the DD/ID 1915(c) waiver);
- Everything you wanted to know about background checks and were afraid to ask...; and
- Intervening Early: Supporting Those who are At-Risk.

MQD conducted on-site health plan reviews during the month of August 2014. A summary of items for corrective action was submitted to health plans in September 2014. All corrective action plans were returned to MQD by September 30, 2014.

Quality Assurance/Monitoring Activity

MQD Quality Strategy

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

We are continuing to work on strategies and measures related to home and community based services, which will affect mostly our QExA health plans, the DDID program, and the Going Home Plus program. MQD submitted a quality grid for monitoring the DDID program to CMS with the recent waiver amendment, and we have been working to implement this. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also been working on behavioral health monitoring and quality improvement. Measures on inpatient care and long-term care will need to be developed in the future in partnership with our stakeholders. Measures for the QUEST and QExA populations will vary.

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

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

Quality Activities during the quarter

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

1. PIPS –Health Services Advisory Group (HSAG) provided feedback to the health plans on their PIPs on July 22, 2014. HSAG provided technical assistance on final preparation of health plans PIPs the end of July 2014. Health plans submitted their final PIPs to HSAG on August 5, 2014.

2. HEDIS – The EQRO issued the final HEDIS validation reports for the five health plans to MQD by July 15, 2014.

3. Compliance Monitoring – The EQRO completed the onsite review with each health plan from May 19 to June 6, 2014. This year the review requirements include 1) Provider Selection 2) Subcontracts and Delegation 3) Credentialing 4) Quality Assurance and Performance Improvement 5) Health Plan Information Systems 6) Practice Guidelines. HSAG staff in conjunction with MQD staff performed on-site reviews for compliance. The corrective action plans requirements were submitted to the three (3) health plans that were requiring corrective action on August 29, 2014. Corrective action plans were returned to HSAG by September 30, 2014.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) – The Star Report for the CAHPS survey for Adults was issued to the MQD on July 9, 2014. The final CAPHS reports was submitted to health plans the beginning of October 2014.

5. Provider Survey – The MQD did not perform a provider survey in 2014.

6. The EQRO will issue its final report to MQD in November 2014.

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

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

Enclosures/Attachments
Attachment A Post Award Public Forum- October 31, 2014
Attachment B QUEST Dashboard- September 2014
Attachment C QExA Dashboard- September 2014

MQD Contact(s)
Jon D. Fujii
Research Officer
601 Kamokila Blvd. Ste. 506A
Kapolei, HI 96707
808 692 8093 (phone)
808 692 8087 (fax)

Date Submitted to CMS
December 1, 2014

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

Agenda Post Award Public Forum
October 31, 2014

1. Opening by George Greene, President, Healthcare Association of Hawaii (HAH)

2. Cost share
    a. Cost share update by Dr. Kenneth S. Fink, Med-QUEST Division Administrator
    b. Panel discussion on cost share questions/issues.
    c. Questions from the audience

3. QI Update by Patricia M. Bazin, Health Care Services Branch Administrator followed by questions from the audience

4. Panel presentation- Q&A to QUEST Integration health plans

5. Open for additional questions

Notice of Post-Award Public Forum on QUEST Integration Medicaid 1115 Demonstration

The Centers for Medicare & Medicaid Services (CMS) approved the State of Hawai'i's section 1115 demonstration project entitled, "QUEST Integration Medicaid 1115 Demonstration" on September 24, 2013. The five year demonstration project, which is administered by the Department of Human Services, Med-QUEST Division (MQD), integrates the previous managed care programs to align with requirements of the Affordable Care Act, provides a more patient-centered healthcare delivery system, and expands access to home and community based services, all with the goal of delivering better health outcomes more efficiently. This demonstration project is currently approved through December 31, 2018.

In accordance with federal transparency requirements under the Affordable Care Act, the State must conduct periodic evaluations related to the implementation of the demonstration project. Therefore, the State of Hawai'i, Department of Human Services, hereby notifies the public that a post-award public forum will be held concurrently with the "QUEST Integration Update" public forum to afford the public with an opportunity to provide meaningful comments on the progress of the demonstration project.

Date:	October 31, 2014
Time:	10:00 a.m. to 12:00 p.m.
Location:	Queen's Conference Center 1301 Punchbowl Street Honolulu, Hawaii 96813

Please register to attend by either e-mailing QUEST_Integration@medicaid.dhs.state.hi.us or calling 808-692-8094 of your attendance by October 29, 2014.

QUEST Integration Forum

October 31, 2014

Hawaii Island, Kauai, Maui, Oahu

HAH
Healthcare Association of Hawaii

The Healthcare Association of Hawaii

Our Vision

A healthy Hawaii where every resident of every age has convenient access to appropriate, affordable, high quality care, and where healthcare providers are reimbursed adequately to deliver that care.

As the unifying voice of Hawaii's healthcare providers and an authoritative and respected leader in shaping healthcare policy in Hawaii, the Healthcare Association of Hawaii (HAH) ***works with committed partners and stakeholders to lead the movement toward achieving an equitable, sustainable Hawaii healthcare system driven to improve quality, efficiency and effectiveness for the patients and communities who entrust their care to us.***

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of Hawaii

Goals

- Continue the conversation.
- Assure partnership and accountability.
- Assess QUEST Integration readiness.
- Prioritize meaningful communication.

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Agenda

- Cost share update
  - Med-QUEST
  - Health Plans
- Med-QUEST update on QUEST Integration
- QUEST Integration Panel
- Questions from providers

Healthcare Association of Hawaii

Please send questions to:

questions@hah.org

Unlike the previous forum, we will stop for questions after each major topic. Depending on time constraints, we may need to limit questions.

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Participants

- Skilled Nursing Facilities
- Assisted Living Facilities
- Hospitals
- Home Health Agencies
- Hospices
- DME Suppliers
- Community Health Centers

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Participants: Moderator

Debbie Hiraoka, MBA

Partner & Co-Founder

HAH
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of Hawaii

Participants: Panelists

QUEST Integration

Kenny Fink, MD

Administrator

Patti Bazin, MBA, MPH, RD, NHA

Health Care Services Branch Administrator

Healthcare Association of Hawaii

Participants: Panelists

AlohaCare
For a healthy Hawaii.

Ford Allison

Senior Director of LTSS

HAH
Healthcare Association
of Hawaii

Participants: Panelists

Kari Lum

Executive Director – LTSS, Medicaid Programs

Participants: Panelists

KAISER PERMANENTE® thrive

Shawn Mehta

VP, Health Plan Service and Administration

HAH Healthcare Association of Hawaii

Participants: Panelists

Wendy Morriarty, MPH, RN

President

Panelists

UnitedHealthcare® Community Plan

David Heywood

President

HAH Healthcare Association of Hawaii

Med-QUEST
Cost Share Update

Healthcare Association of Hawaii

MQD Cost Share Update

- Who do we notify if we continue to have incorrect cost shares?
- We have several residents who had their cost shares adjusted prior to May 2014. In most cases families were not notified of the changes (increases) to cost share. Who do we contact regarding this and who should we tell families to contact other than their eligibility worker, whom many say they have not been assigned one or are never able to speak to a live person.
- How can we find out who the case worker is?

Panel Discussion – COST SHARE UPDATE

- How does your plan update its records for cost share information?
- What should a provider do if plan cost share differs from MQD cost share?
- For UHC and Ohana:
  - What should providers do to correct claims with incorrect cost share amounts?
  - When do you anticipate claim differences to be resolved?

Med-QUEST

QUEST Integration Update

Healthcare Association of Hawaii

MQD QUEST Integration Update

- What is the status of the open enrollment period? How many people moved between plans by island and by QUEST vs. QExA?
- What is the status of the health plan readiness reviews?
- Can you please re-confirm the absolute deadline that all QUEST Integration contracts between provider and health plans must be in place before Go Live?

MQD QUEST Integration Update

- During the transition period Jan. 2015 - Mar 2015 beneficiary will have the opportunity to change plans, if the provider has an authorization for services with plan 1 & beneficiary changes to plan 2 will the plan 2 honor/accept plan 1 authorization? Or, does this again become the responsibility of the provider finding out after services/claims have already been provided. Will there be an opportunity for the provider to get a "retro" from plan 2?

Panel Discussion – PROVIDER EDUCATION

- When will provider meetings/trainings be held? Need to know specific dates, times and locations
- How will the information be distributed for sign up etc. once the dates, times and locations are finalized for the health plans hosting provider training? Will we receive notification through the mail or some other way?
- What information will be available electronically? (i.e. a web based electronic claim status or eligibility verification)

Panel Discussion – PRIOR AUTHORIZATIONS

- Will there be/are there provisions requiring a health plan to issue a retro authorization and waive notification requirements for providers when a beneficiary is issued retro eligibility as the provider is not notified when a beneficiary receives retro eligibility and therefore cannot realistically be expected to issue a notification within the allotted timeframe of the retro eligibility being granted.
- Will you provide the providers with education/information of the services/equipment that will be covered/require prior authorization under the QI Program or does each plan have their own plan coverage - Example, HMSA does cover Incontinence w/ no fee schedule, Ohana does not require prior authorization for items under $250 per line item & UHC does not require prior authorization for items under $500.

Panel Discussion – SERVICE COORDINATORS

- What are the new expectations of the service coordinators? What is the difference between their role and provider reps?
- How many clients will the service coordinators have?
- Commitment to service coordinators in facilities every week, when can we anticipate that starting? What will they be doing in the facility and more importantly, what will the facility have to do for them?
- Will there be provider representative(s) for the DME community?

Panel Discussion – SERVICE COORDINATORS

- In the education process, will the service/field service coordinator / call centers have knowledge of the health plans requirements that the providers MUST have in place/on file PRIOR TO Submitting Claims?
- In terms of your selection process, will the service coordinators have any clinical background? Can we expect that the service coordinators assigned to the LTC/ sub acute population will be knowledgeable in the needs of the med fragile population?
- Do provider service representatives and claims department receive the same training? We currently get very different information from the two departments.

Panel Discussion – Claims and Other

- What is available to the provider electronically:
  - Enrollment verification
  - Cost share information
  - Claims submission
  - Claims status
- Will you be using the patient's Medicaid ID number or your own number for claims submission?
- Can all 5 plans offer the same type of bill requirements (i.e. corrected claims – use TOB xx7)?

Panel Discussion – Enrollment and COB

- What is the process if there is a discrepancy between what the health plan is showing and what MQD website is showing (i.e. when the health plan shows an individual not active and states that they are not able to update this without verification but this is clearly visible to the provider on the MQD website)?
- Along the same lines - will you verify eligibility with their own commercial products (i.e. The patient is shown with HMSA commercial as primary to their HMSA Quest plan, however the HMSA commercial plan shows that the coverage termed on a prior date, Quest HMSA states that they cannot update this)?

Thank you for coming!

Save the Date: January 2015

Information is available at:

http://hah.org/?p=3555

Password: Quest092614

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QUEST Integration Forum

Patricia M. Bazin
MQD Health Care Services Branch Administrator

October 31, 2014

Outline

QUEST Integration

- Benefits
- Service coordination
- Administrative simplification
- Open enrollment
- Transition of care
- Health plan readiness

QUEST Integration Benefits

- All primary and acute care
  - Hospitalization
  - Physician
  - Medications
  - DME
  - Medical supplies (including incontinence products)
- Standard behavioral health
  - Psychiatrist, psychologist, etc.
  - Psychotropic medications

QUEST Integration Benefits

- Long-Term Services and Supports
  - Meet nursing facility LOC to receive:
    - Nursing facility (ICF/SNF/subacute)
    - Home and Community Based Services
      - Personal Care (both Chore and ADLs)
      - Skilled Nursing
      - Residential settings (E-ARCH, Community Care Foster Family Home, ALF)
  - Meet at-risk criteria to receive services
    - Personal Care (both Chore and ADLs)
    - Adult Day Care and Health
    - Skilled Nursing
    - Personal Emergency Response System (PERS)
    - Home Delivered Meals

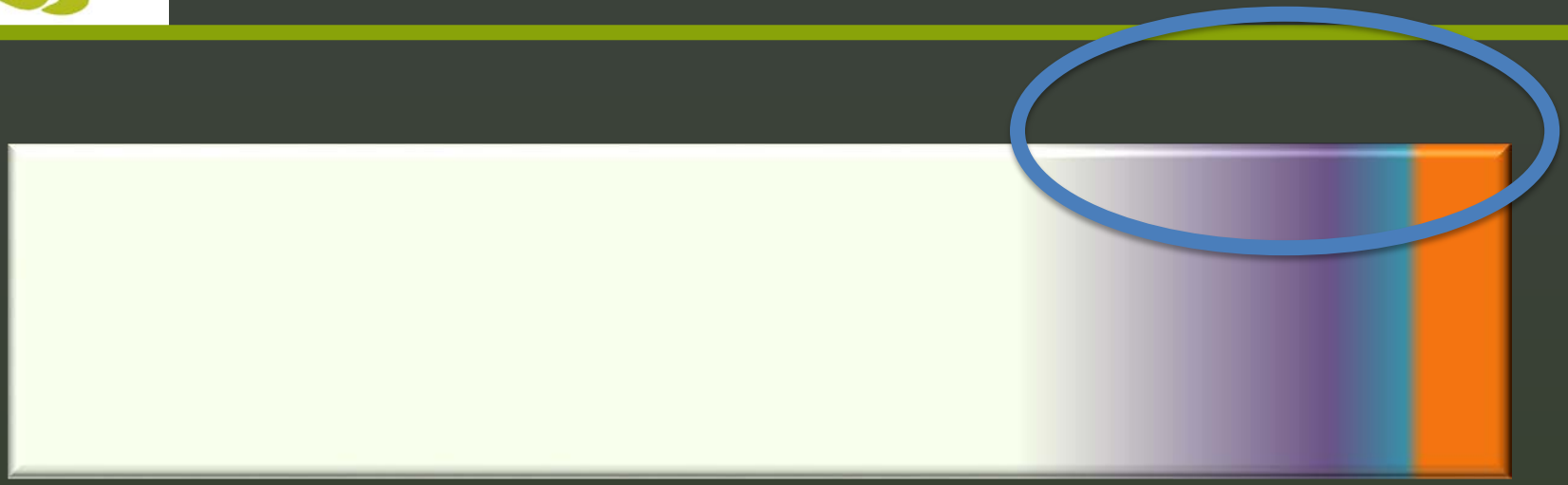
DHS 1147

- Tool to meet:
  - Nursing facility level of care (NF LOC)
  - At risk criteria
- No changes in process for QUEST Integration
  - All 1147s remain in effect
  - No change in roles of HSAG, MQD, or health plans

Population served in QI

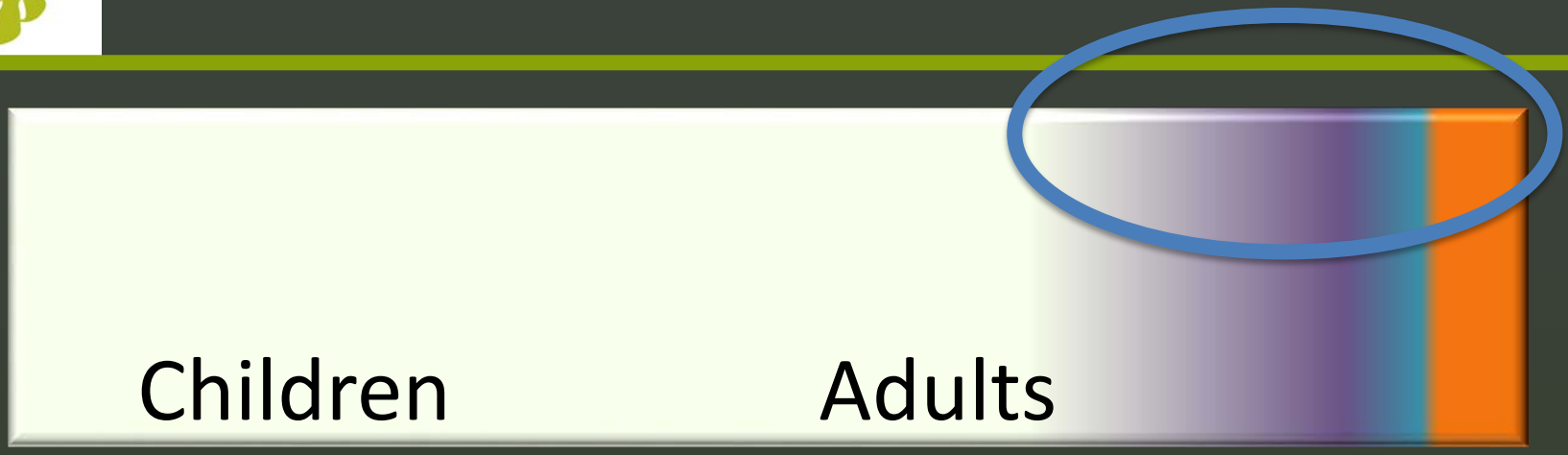
Typical population:
children, pregnant women, parent/caretaker relative, low-income adults, 65 years and older, with a disability

Rest of the Continuum



Health plans are to provide service coordination to insure that the member receives supervised, coordinated services and supports to achieve quality of life and optimal health

Who receives service coordination?



Children	Adults
☐ Special Health Care Needs (SHCN)	☐ Special Health Care Needs (SHCN)
Identified by: ☐ • PCP • Parents • Health Plan • Agencies	Identified by: ☐ • PCP • Self/Designee • Health Plan • Agencies
☐ Receives LTSS	☐ Receives LTSS
	☐ Dual eligibles

Staffing Ratio

Population	Ratio
Children with SHCN	1:200
Adults with SHCN	1:250
Dual eligibles	1:750
HCBS only	1:50
Self Direction only	1:30
Institutional LOC	1:120
HCBS and Self Direction	1:40

Initial Assessments- in person

Existing Member Newly Identified or Referred

- 15 days – Health & Functional Assessment, in person
- 90 days- during transition of care

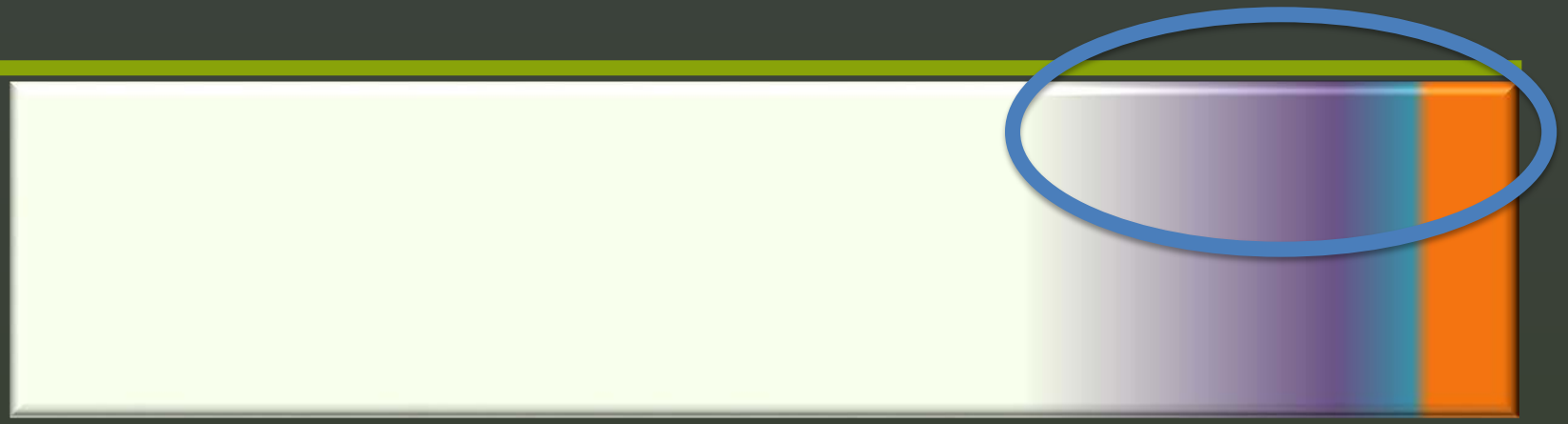
Member Who is Institutionalized

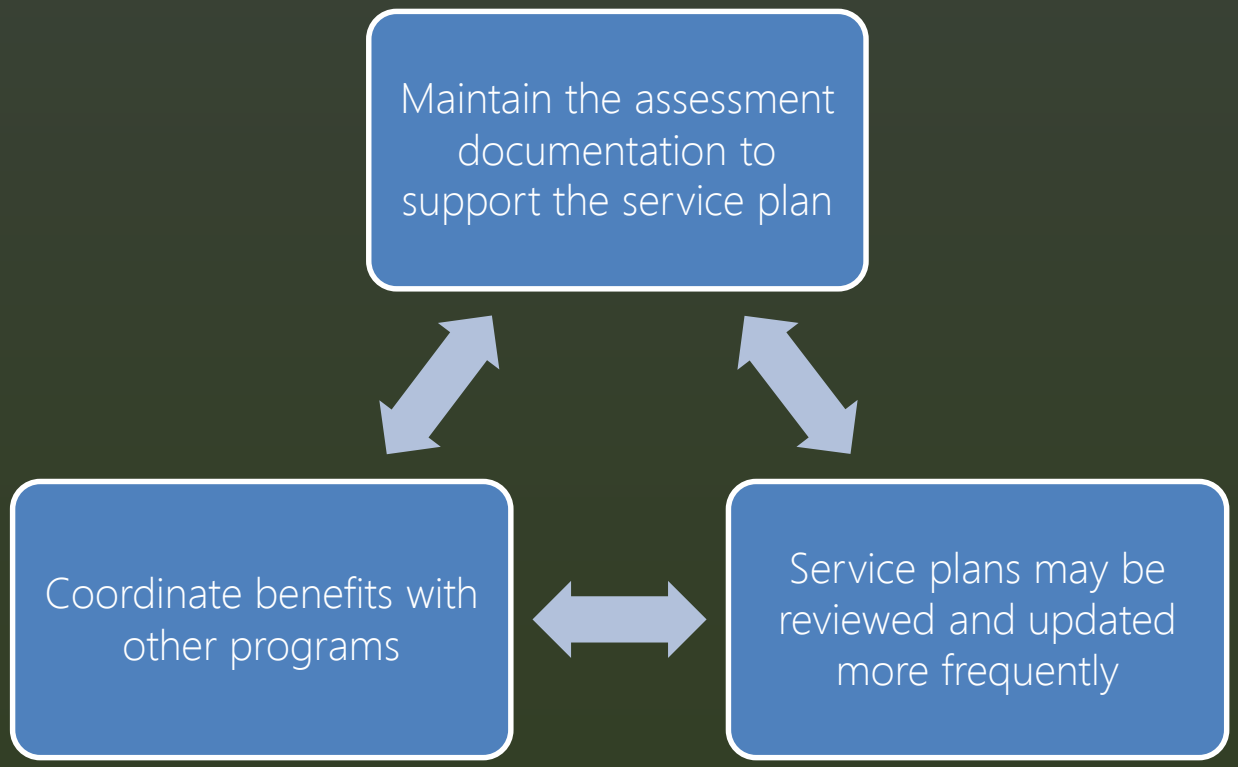
- Prior to Discharge – in person, in the facility
- Post Discharge – in person, in the home

Reassessments – in person

No Known Change	At-Risk HCBS Self-Directed	3 months
	Children w/SHCN Adults w/SHCN Nursing Facility	6 months
	Dual eligible w/out SHCN or receiving LTSS	12 months
Change in Condition or Significant Event	Death of a caregiver Significant change in health status Change in living arrangement Institutionalization Hospitalization	10 days

Service Coordination





Coordination with Other Programs

- Service coordinators need to coordinate with the following programs/services :
  - Community Care Services (CCS)
  - Child and Adolescent Mental Health Division (CAMHD)
  - Kapi‘olani Cleft Palate Clinic
  - Adult Mental Health Division (AMHD) and State Mental Hospital (SMH)
  - Intentional termination of pregnancy (ITOPs)
  - Developmental Disabilities/Intellectual Disabilities (DD/ID) 1915(c) waiver

Administrative Simplification

- QUEST Integration program requires:
  - Provider webportal that includes:
    - Membership verification
    - Electronic prior authorization request and approval
    - Filled medication look-up list
    - Electronic referrals requiring authorization
  - Provider call center that:
    - Meets call metrics
    - Accepts messages after hours
    - 30-minute return for emergency calls

Administrative Simplification

- QUEST Integration program requires:
  - Smart PA system
    - Waiver or reduce PA requirements for providers that have a certain percentage of PA request approved
    - Different for each health plan
  - Retro authorizations
    - Work with providers on submission of authorization requests for retro eligibility
  - Incentivize electronic claim submission
  - Medicare cross over
    - Traditional Medicare
    - Medicare advantage of same QI health plan

Open Enrollment

- September 2 to 30, 2014
- Choice of five health plans
- Individuals stay in current health plan if no choice
- Confirmation notices mailed mid-December 2014
- Member use confirmation notice as proof of insurance until receipt of ID card (mid-January 2015)
- 60-day grace period to change health plans from January 1 to March 1, 2015

Open Enrollment

Final Open Enrollment Numbers

	Non-ABD	ABD	Total
Oahu	4,300	1,883	6,183
Kauai	431	119	550
Hawaii	1,366	453	1,819
Maui	1,293	260	1,553
Molokai	173	42	215
Lanai	19	9	28
Total	7,582	2,766	10,348

Transition of Care

- All prior authorized LTSS for 90-days (or until assessed by service coordinator) in new health plan
- All prior authorized medically necessary services for 45-days (or until seen by PCP) in new health plan
- Health plans receive transition of care files that include prior authorizations- end of November and December 2014

Transition of Care

- Providers need to:
  - look up beneficiaries in DMO after January 1, 2015, or
  - make arrangements with health plans
- Recommend obtain prior authorization from new health plan for ongoing services
- Note: each health plan has their own prior authorization processes

Readiness Review

- All five health plans are still undergoing readiness review processes
- LTSS providers offered claims testing with health plans
- Claim scenarios for LTSS testing issued by MQD
- Health plans provide two summaries to MQD regarding claims testing with LTSS provider:
  - October 31, 2014
  - November 30, 2014

Health Plan monitoring

- MQD perform oversight of transition
  - In field with service coordinators
  - Monitoring change in services (reduction and increase)
  - Listening into customer service calls (member and provider)
- Reviewing reports
- Customer satisfaction surveys
  - Member
  - Provider

Important Dates

Event	Dates
Readiness Review- MQD determines health plans ready	November 30, 2014
Members mailed confirmation notice	Mid-December 2014
Go Live	January 1, 2015
Providers learn of new health plans	January 1, 2015
Transition of Care • Transfer prior authorization files between health plans	November/December 2014
• Former prior authorizations remain for medical services	January 1 to February 14, 2015
• Former prior authorizations remain for LTSS	January 1 to March 31, 2015
Service Coordinator assessments for individuals with SHCN and receiving LTSS	January 1 to March 31, 2015

Questions

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QUEST Program
Summary of Monthly Trends
SFY 15

Attachment B

	Jul-14					Aug-14					Sep-14				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
QUEST Adult	30,202	63,119	8,883	10,901	9,907	29,342	62,639	8,764	10,788	9,855	28,715	62,031	8,519	10,674	9,850
QUEST Keiki	37,121	83,281	16,292	4,755	4,194	35,945	81,884	15,919	4,687	4,190	35,152	80,600	15,279	4,726	4,231
Total	**67,323**	**146,400**	**25,175**	**15,656**	**14,101**	**65,287**	**144,523**	**24,683**	**15,475**	**14,045**	**63,867**	**142,631**	**23,798**	**15,400**	**14,081**
# Network Providers															
PCPs	551	756	212	585	597	561	741	217	594	598	443	462	7	589	600
PCPs - #in Clinics (ex. FQHC, CHC, etc.)					27				96	27	118	306	215	96	27
Specialists	2,104	2,592	533	1794	1,806	2,113	2,647	538	1816	1,813	2134	2640	547	1819	1,818
Behavioral Health	653	1,243	150	548	701	660	1,249	152	556	706	662	1260	154	563	713
Facilities (Hosp./NF)	35	24	52	51	46	35	24	52	51	46	49	24	52	51	46
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	1,466	1,153	329	1325	634	1,467	1,159	331	1337	625	1,480	1,149	331	1351	630
Total # of providers	**4,809**	**5,768**	**1,276**	**4,303**	**3,811**	**4,836**	**5,820**	**1073**	**4,450**	**3,815**	**4,886**	**5,841**	**1,306**	**4,469**	**3,834**
Call Center															
# Member Calls	4,736	16,064	538	2,648	1,649	4,831	12,589	437	2,340	1,519	6,066	16,019	541	2,440	1,777
Avg. time until phone answered	0:00:06	3:44:00	0:00:15	0:00:11	00:20	0:00:12	5:06	0:00:13	0:00:08	00:16	0:00:35	13:44	0:00:12	0:00:15	00:09
Avg. time on phone with member	3:02	2:44:00	3:00:00	0:07	05:46	2:54	4:08	2:58	0:07	06:01	3:07	4:38	3:09	0:07	05:23
% of member calls abandoned	1.5%	24.82%	2.50%	5.4%	2.4%	3.6%	30.06%	2.30%	2.6%	1.3%	9.8%	55.19%	2.30%	2.4%	0.6%
# Provider Calls	8,707	14,282	N/A	292	684	7,363	9,745	N/A	257	511	8,787	10,704	N/A	294	466
Avg. time until phone answered	0:00:07	0:44:00	N/A	0:00:05	00:05	0:00:15	6:01	N/A	0:00:07	00:04	0:00:38	12:07	N/A	0:00:09	00:04
Avg. time on phone with provider	3:20	1:27:00	N/A	0:07	05:54	3:19	4:11	N/A	0:09	06:52	3:19	4:40	N/A	0:07	06:42
% of provider calls abandoned	1.2%	5.69%	N/A	1.7%	0.2%	2.3%	33.58%	N/A	0.8%	0.4%	8.3%	46.64%	N/A	1.7%	0.2%
Medical Claims - Electronic															
# Submitted, not able to get into system	1,622	7,397	10	547	685	1,069	7,690	11	561	639	1,259	6,886	13	544	650
# Received	34,644	270,396	269	11,867	13,713	33,940	262,108	242	11,413	12,798	38,476	287,686	269	13,066	13,005
# Paid	34,304	283,765	186	10,917	12,410	29,075	220,511	160	11,637	10,424	34,643	239,183	189	10,622	12,020
# In Process	2,843	83,538	191	836	34	5,163	109,941	165	970	93	6,644	141,410	196	839	188
# Denied	2,352	19,695	5	1,161	2,149	2,386	15,083	4	1,416	1,953	2,414	16,980	7	1,320	1,868
Avg time for processing claim in days (month to date)	4	12	13	9	8	4	12	14	10	7	4	12	10	9	8
Medical Claims - Paper															
# Submitted, not able to get into system	470	1,307	96	228	88	461	1,498	110	148	93	432	2,101	137	153	169
# Received	20,852	33,284	2,714	3,627	1,773	19,860	42,403	2445	3,117	1,867	19,852	49,846	2,717	3,415	3,393
# Paid	19,277	48,657	1,886	2,689	1,541	15,685	41,820	1621	2,909	1,298	17,696	52,339	1,910	2,677	1,447
# In Process	5,973	20,848	1,932	705	14	5,875	34,856	1662	631	67	5,013	35,475	1,978	608	128
# Denied	3,998	8,425	46	560	414	2,192	7,419	42	676	399	2,823	7,657	68	615	444
Avg time for processing claim in days (month-to-date)	7	25	13	11	12	7	28	14	12	10	8	23	10	11	12
Prior Authorization (PA)- Electronic															
# Received	148	307	132	10	9	149	267	127	6	6	146	244	150	10	12
# In Process	13	96	0	0	0	27	125	0	0	0	21	79	0	0	0
# Approved	133	263	131	10	9	121	201	123	6	6	125	238	140	10	11
# Denied	2	41	1	0	0	1	37	4	0	0	0	52	10	0	1
Avg time for PA in days (month to date)	9	10	5	0	10	11	10	5	0	7	7	11	4	0	3
Prior Authorization (PA)- Paper and Telephone															
# Received	3,313	540	1	197	1,042	3,097	538	3	163	738	3,376	622	0	194	913
# In Process	328	8	0	1	10	652	5	0	16	7	764	0	0	23	12
# Approved	2,968	409	0	190	1,014	2,435	402	0	146	711	2,724	483	0	171	854
# Denied	17	131	1	6	18	10	144	3	1	20	12	144	0	0	47
Avg time for PA in days (month-to-date)	5	0	11	5	4	6	0	13	4	4	6	0	0	4	3
# Non-Emergency Transports															
Ground	575	638	41	534	364	542	672	54	525	369	545	717	62	587	415
Air	447	660	1	98	18	389	660	1	86	19	395	698	0	86	17
* round trip															
# Member Grievance															
# Received	11	10	4	8	5	12	4	7	5	9	14	2	5	15	3
# Resolved	7	7	7	6	6	13	9	5	10	6	13	5	5	6	6
# Outstanding	7	9	1	9	3	6	4	3	4	6	7	1	3	13	3
# Provider Grievance															
# Received	0	0	0	0	3	0	0	0	0	0	1	0	0	0	0
# Resolved	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
# Outstanding	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0
# Member Appeals															
# Received	4	21	2	1	0	0	35	1	1	1	1	35	0	0	0
# Resolved	3	24	4	1	2	2	24	3	1	0	0	40	0	1	1
# Outstanding	2	13	2	1	0	0	24	0	1	1	1	19	0	0	0
# Provider Appeals															
# Received	0	5	1	11	21	0	1	0	31	16	0	3	0	15	24
# Resolved	0	2	0	6	18	0	1	1	11	18	0	6	0	20	24
# Outstanding	0	8	1	21	15	0	8	0	41	13	0	5	0	36	13
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits (A) - per 1,000	83	131	3	106	130	86	133	3	113	95	80	142	3	130	124
Inpatient Acute Days (A) - per 1,000	315	543	10	521	582	336	591	12	453	449	297	599	10	530	524
Inpatient Acute Psych Admits (A)- per 1,000	6	1	0	17	6	5	1	0	11	11	6	1	1	15	14
Inpatient Acute Psych Days (A)- per 1,000	31	5	4	49	24	24	4	2	107	53	24	5	4	57	47
Readmissions within 30 days (A)	43	278	0	17	15	31	279	0	23	13	36	294	0	27	12
Waitlisted Days (A) - per 1,000	49	8	1	0	0	27	11	1	0	0	26	10	1	34	0
ER Visits (C) - per 1,000	546	428	19	642	529	548	436	20	585	590	577	464	19	645	552
# Prescriptions (C) - per 1,000	7,913	9,530	648	9,192	8,628	7,828	9,518	641	9,194	8,535	8,385	9,934	630	9,404	9,165

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

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

QUEST Program
Summary of Monthly Trends
SFY 15

Attachment B

as of: 9/30/2014

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)	264	52	9	1	38	39	40	443
PCPs - (accepting new members)	**174**	**26**	**7**	**1**	**27**	**21**	**30**	**286**
PCPs - Clinics (e.g. FQHC, CHC, etc.)	64	9	3	2	3	18	19	118
PCPs - Clinics (accepting new members)	**55**	**9**	**3**	**2**	**2**	**16**	**18**	**105**
Specialists	1610	171	24	2	117	102	108	2,134
Specialists (accepting new members)	**680**	**84**	**6**	**1**	**47**	**34**	**45**	**897**
Behavioral Health	408	84	4	3	42	60	61	662
Behavioral Health (accepting new members)	**294**	**58**	**3**	**2**	**32**	**49**	**47**	**485**
Facilities (Hosp./NF)	24	4	1	2	7	2	9	49
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	978	168	13	12	103	110	96	1,480
Totals	**3,348**	**488**	**54**	**22**	**310**	**331**	**333**	**4,886**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	33,148	9,238	2125	468	5,742	6,649	6,497	63,867

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	101	151	177	156	140	117	110	114

Note: RFP requirement is 300 members for every PCP

HMSA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)	324	26	5	0	29	48	30	462
PCPs - (accepting new members)	**160**	**7**	**1**	**0**	**22**	**6**	**16**	**212**
PCPs - Clinics (e.g. FQHC, CHC, etc.)	153	33	4	18	15	29	54	306
PCPs - Clinics (accepting new members)	**33**	**6**	**4**	**1**	**13**	**6**	**24**	**87**
Specialists	1770	239	39	13	176	154	249	2,640
Specialists (accepting new members)	**1770**	**239**	**39**	**13**	**176**	**154**	**249**	**2,640**
Behavioral Health	786	130	6	3	80	138	117	1,260
Behavioral Health (accepting new members)	**786**	**130**	**6**	**3**	**80**	**138**	**117**	**1,260**
Facilities (Hosp./NF)	11	2	1	1	3	1	5	24
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	683	143	11	17	86	94	115	1,149
Totals	**3,727**	**573**	**66**	**52**	**389**	**464**	**570**	**5,841**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	89,500	7,958	547	106	7,858	22,589	14,073	142,631

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	188	135	61	6	179	293	168	186

Note: RFP requirement is 300 members for every PCP

as of: **9/30/2014**

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)	**0**	**0**	**4**	**3**	**0**	**0**	**0**	7
PCPs - (accepting new members)	0	0	4	3	0	0	0	**7**
PCPs - Clinics (e.g. FQHC, CHC, etc.)	121	41	0	0	21	15	17	215
PCPs - Clinics (accepting new members)	**114**	**40**	**0**	**0**	**21**	**15**	**17**	**207**
Specialists	**395**	**60**	**1**	**0**	**46**	**20**	**25**	547
Specialists (accepting new members)	395	60	1	0	46	20	25	**547**
Behavioral Health	**108**	**18**	**0**	**1**	**11**	**8**	**8**	154
Behavioral Health (accepting new members)	**108**	**18**	**0**	**1**	**11**	**8**	**8**	**154**
Facilities (Hosp./NF)	**35**	**3**	**1**	**1**	**3**	**7**	**2**	52
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	**200**	**45**	**4**	**4**	**37**	**17**	**24**	331
Totals	**859**	**167**	**10**	**9**	**118**	**67**	**76**	**1,306**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	15,768	8,030						23,798

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	130	196	0	0	0	0	0	107

Note: RFP requirement is 300 members for every PCP

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)	388	52	3	6	46	64	30	589
PCPs - (accepting new members)	**169**	**21**	**3**	**1**	**21**	**22**	**10**	**247**
PCPs - Clinics (e.g. FQHC, CHC, etc.)	67	2	1	1	2	10	13	96
PCPs - Clinics (accepting new members)	**67**	**2**	**1**	**1**	**2**	**10**	**13**	**96**
Specialists	1468	87	13	4	114	75	58	1,819
Specialists (accepting new members)	**990**	**82**	**13**	**0**	**38**	**73**	**54**	**1,250**
Behavioral Health	403	36	1	0	28	62	33	563
Behavioral Health (accepting new members)	**328**	**33**	**1**	**0**	**19**	**51**	**25**	**457**
Facilities (Hosp./NF)	27	5	2	1	7	2	7	51
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	872	142	17	6	81	117	116	1,351
Totals	**3,225**	**324**	**37**	**18**	**278**	**330**	**257**	**4,469**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	8857	2011	146	38	968	1846	1534	15,400

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	19	37	37	5	20	25	36	22

Note: RFP requirement is 300 members for every PCP

as of: **9/30/2014**

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC less est 100 FQHC PCPs)	474	65	0	0	61	52	42	**694**
PCPs (accepting new members)	393	58	0	0	58	23	38	**570**
PCPs - # in Clinics (e.g. FQHC)	11	0	0	0	0	17	1	**29**
PCPs (in Clinic, accepting new members)	11	0	0	0	0	17	1	**29**
Specialists	1936	173	0	0	193	101	95	**2,498**
Specialist (accepting new members)	1414	167	0	0	180	61	92	**1,914**
Behavioral Health	570	81	0	0	26	63	35	**775**
Behavioral Health (accepting new members)	555	74	0	0	24	58	33	**744**
Facilities (Hosp./NF)	38	16	0	0	7	14	7	**82**
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	507	90	0	0	72	62	64	**795**
Totals	**3,547**	**425**	**0**	**0**	**359**	**326**	**245**	**4,902**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	**8,309**	**1,766**	**128**	**33**	**913**	**1,692**	**1,240**	**14,081**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	18	27	#DIV/0!	#DIV/0!	15	33	30	**20**

Note: RFP requirement is 300 members for every PCP

Attachment C

QExA Dashboard Report
Health Plan Comparison
SFY 2014 Monthly Trend Analysis

	July '14		August '14		September '14	
	Ohana	United	Ohana	United	Ohana	United
# Members						
Medicaid	10,242	7,026	10,346	7,036	10,418	7,117
Duals	15,539	15,982	15,440	15,965	15,481	16,037
Total Members	**25,781**	**23,008**	**25,786**	**23,001**	**25,899**	**23,154**
# Network Providers						
PCPs	554	753	559	753	550	755
PCPs - # in Clinics (e.g. FQHC, CHC, etc.)		41	67	41	67	41
Specialists	2136	2,548	2151	2,562	2149	2,573
Facilities (Hosp./NF)	63	46	63	46	63	46
Foster Homes (FH) (CCFHH only; no E-ARCH)	1010	931	1012	936	1018	937
HCBS Providers (All LTC, except CCFHH and NF)	157	386	157	390	157	390
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, BH, Allied, Hospice, HHA)	1,640	743	1,651	742	1,672	749
Total # of providers	**5,560**	**5,448**	**5,660**	**5,470**	**5,676**	**5,491**
Call Center						
# Member Calls	9,657	3,485	8,521	3,422	9,375	3,759
Avg. time until phone answered	0:00:11	00:24	0:00:09	00:14	0:00:16	00:10
Avg. time on phone with member	0:07	06:20	0:07	05:38	0:07	05:14
% of member calls abandoned	5%	2.7%	3%	1.8%	3%	1.1%
# Provider Calls	4,973	2,822	4,661	2,346	4,526	2,743
Avg. time until phone answered	0:00:13	00:04	0:00:11	00:00	0:00:22	00:01
Avg. time on phone with provider	0:08	06:47	0:08	07:52	0:08	07:22
% of provider calls abandoned	1%	0.6%	1%	0.0%	2%	0.3%
Medical Claims- Electronic						
# Submitted, not able to get into system	2,157	2,276	2,565	2,078	2,566	1,863
# Received	53,056	45,522	55,380	41,569	53,823	37,277
# Paid	38,901	35,696	48,522	32,393	39,876	33,108
# In Process	10,308	801	8,372	885	7,261	1,114
# Denied	8,665	11,066	14,255	9,579	11,574	8,446
Avg time for processing claim in days	11	10	12	9	10	10
* unable to break out (month to date)						
Medical Claims- Paper						
# Submitted, not able to get into system	747	1,288	657	1,224	537	1,620
# Received	16,863	25,765	15,197	24,496	15,885	32,401
# Paid	9,976	20,121	12,448	18,174	10,441	16,929
# In Process	5,496	1,770	4,746	4,100	4,444	4,744
# Denied	3,593	7,559	5,472	7,255	4,388	6,560
Avg time for processing claim in days (month-to-date)	13	10	15	7	15	8
Prior Authorization (PA)- Electronic						
# Received	33	34	29	47	45	53
# In Process	1	0	0	3	0	18
# Approved	32	33	29	43	44	35
# Denied	0	1	0	1	1	0
Avg time for PA in days (month to date)	1	6	1	6	1	6
Prior Authorization (PA)- Paper and Telephone						
# Received	659	3,918	572	3,446	713	3,491
# In Process	24	117	27	113	50	159
# Approved	619	3,551	535	3,098	646	3,081
# Denied	16	250	10	235	17	251
Avg time for PA in days (month-to-date)	5	3	5	3	5	3
# Non-Emergency Transports						
Ground	9,745	8,071	9,034	7,357	9,411	7737
Air	617	147	502	129	569	131
* round trip						
# Member Grievance						
# Received	74	70	70	44	81	72
# Resolved	91	83	86	39	71	47
# Outstanding	74	16	58	21	68	46
# Provider Grievance						
# Received	2	3	0	0	1	0
# Resolved	3	3	3	0	2	0
# Outstanding	6	0	3	0	2	0
# Member Appeals						
# Received	2	3	2	7	3	4
# Resolved	3	3	3	2	3	7
# Outstanding	3	3	2	8	2	5
# Provider Appeals						
# Received	29	42	62	51	47	53
# Resolved	26	49	12	32	37	63
# Outstanding	43	30	93	49	103	39
Utilization - based on Auth (A) or Claims (C)						
Inpatient Acute Admits * (A) - per 1,000	273	259	270	211	262	219
Inpatient Acute Days * (A) - per 1,000	1,837	1,486	1,903	1,229	1,643	1,297
Readmissions within 30 days* (A)	73	29	60	25	55	17
ER Visits * (C) - per 1,000**	1,189	967	1,038	951	1,117	900
# Prescriptions (C) - per 1,000	20,934	20,342	20,303	19,464	20,795	19,500
Waitlisted Days * (A) - per 1,000	334	49	270	100	157	146
NF Admits * (A)	1	1	3	3	4	3
# Members in NF (non-Medicare paid days) (C)**	1,383	1,222	1,224	1,180	1,296	1,165
# Members in HCBS **(C)- note: member can be included in more than one category listed below	2,191	2,574	2,146	2,451	2,235	2,518
# Members in FH **(C)	694	1,049	671	1,013	676	1,026
# Members in Self-Direction **(C)	858	908	829	879	876	882
# Members receiving other HCBS **(C)	1,333	984	1,317	895	1,359	955
NF Days (non-Medicare covered days) (C)						
(* non-Medicare) (**lag in data of two months)						

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

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

* Duplicates included

QExA Health Plan Demographic Information by Island

as of: **September 30, 2014**

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	Hawaii	Hawaii	Totals
PCPs - (Traditional)	341	53	5	3	44	72	32	550
PCPs - (accepting new members)	**172**	**20**	**3**	**1**	**18**	**20**	**10**	**244**
PCPs - Clinics (e.g. FQHC, CHC, etc.)	38	2	1	1	2	10	13	67
PCPs - Clinics (accepting new members)	**38**	**2**	**1**	**1**	**2**	**10**	**13**	**67**
Specialists	1732	113	14	0	102	108	80	2,149
Specialists (accepting new members)	**1561**	**103**	**14**	**0**	**98**	**94**	**70**	**1,940**
Foster Homes (FH) (CCFFH only; no ARCH)	855	41	0	0	14	81	27	1,018
HCBS Providers (All LTC, except CCFFH and NF)	**109**	**9**	**2**	**0**	**6**	**23**	**8**	157
Facilities (Hosp./NF)	36	5	2	1	7	4	8	63
Ancilliary & Other (All provider types not listed above; incl Phcy, Lab, Allied, Hospice, HHA)	1073	169	18	6	117	154	135	1,672
Totals	**4,184**	**392**	**42**	**11**	**292**	**452**	**303**	**5,676**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	17,014	2,443	386	88	957	3,530	1,481	**25,899**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	45	44	64	22	21	43	33	42

Note: RFP requirement is 600 members for every PCP

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs (incl FQHC)	611	73	0	0	78	58	46	**866**
PCPs (accepting new members)	511	63	0	0	74	36	36	**720**
PCPs - # in Clinics (e.g. FQHC)	19	0	0	0	6	17	1	**43**
PCPs (in Clinic, accepting new members)	19	0	0	0	6	17	1	**43**
Specialists	2,532	257	0	0	218	161	157	**3,325**
Specialist (accepting new members)	2,356	253	0	0	215	128	155	**3,107**
Facilities (Hosp./NF)	58	18	0	0	7	18	8	**109**
Foster Homes (FH) (xARCH)	787	30	0	0	16	89	21	**943**
HCBS Providers (All LTC, xFH & NF)	319	25	0	0	11	30	8	**393**
Ancilliary & Other (All not listed above)	603	112	0	0	81	80	68	**944**
Totals	**4,948**	**515**	**0**	**0**	**423**	**470**	**310**	**6,666**

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members	15,343	1,551	0	0	1,318	3,600	1,342	**23,154**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Members per PCP	25	21	#DIV/0!	#DIV/0!	17	62	29	**27**

as of: **September 30, 2014**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	589	99	11	3	39	152	44	**937**
Network (provider look up, access)	59	17	3	0	2	16	6	**103**
Primary Care Physician Assignment or Change	276	51	10	3	29	70	42	**481**
NEMT (inquiry, scheduling) -*monthly report*	876	34	3	1	7	58	0	**979**
Authorization/Notification (prior auth status)	48	40	15	0	12	46	36	**197**
Eligibility (general plan eligiblity, change request)	140	19	1	1	7	28	22	**218**
Benefits (coverage inquiry)	199	44	8	0	12	58	30	**351**
Enrollment (ID card request, update member information)	509	84	16	1	41	141	65	**857**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	260	61	12	1	12	52	25	**423**
Billing/Payment/Claims	103	15	2	0	1	16	10	**147**
Appeals	2	1	0	0	0	0	0	**3**
Complaints and Grievances	41	5	2	0	2	11	1	**62**
Other	1064	210	38	7	78	214	125	**1736**
Totals	**4,166**	**680**	**121**	**17**	**242**	**862**	**406**	**6,494**

UnitedHealthcare

Summary of Calls by Island	Oahu	Maui	Kauai	Lanai	Molokai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	**8**	**1**	**4**	**0**	**1**	**1**	**2**	**17**
Network (provider look up, access)	**47**	**7**	**18**	**2**	**12**	**11**	**4**	**101**
Primary Care Physician Assignment or Change	**113**	**17**	**56**	**7**	**9**	**34**	**12**	**248**
NEMT (inquiry, scheduling) -*monthly report**	**3,353**	**365**	**193**	**14**	**9**	**702**	**568**	**5,204**
Authorization/Notification (prior auth status)	**99**	**25**	**42**	**8**	**19**	**48**	**23**	**264**
Eligibility (general plan eligiblity, change request)	**994**	**120**	**291**	**20**	**86**	**258**	**98**	**1,867**
Benefits (coverage inquiry)	**63**	**19**	**7**	**1**	**10**	**23**	**13**	**136**
Enrollment (ID card request, update member information)	**419**	**62**	**78**	**12**	**24**	**132**	**63**	**790**
Service Coordination Inquiry or request (contact FSC, assessment, plan of care)	**172**	**14**	**48**	**3**	**14**	**53**	**11**	**315**
Billing/Payment/Claims	**990**	**97**	**524**	**48**	**108**	**228**	**24**	**2,019**
Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Complaints and Grievances	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other	**271**	33	118	10	33	89	30	**584**
Totals	**6,529**	**760**	**1,379**	**125**	**325**	**1,579**	**848**	**11,545**

*Calls logged via Logisticare call center

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