

## **Attachment B**

**Hawaii QUEST Expanded  
Section 1115 Demonstration Waiver**

**Interim Demonstration Evaluation Report**  
September 5, 2012

**Demonstration Year Ending: June 30, 2012**



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## Executive Summary

The demonstration evaluation period for this report is from January 1, 2008 to June 30, 2012. This concludes the 18<sup>th</sup> demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period has seen several significant initiatives for the QUEST Expanded program:

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

Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: ‘Ohana Health Plan and UnitedHealthcare Community Plan. As of June 30, 2012, the QExA program has approximately 45,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:

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

- **Reprocurement of the QUEST program.**

The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of June 30, 2012, the QUEST program has approximately 239,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans: ‘Ohana Health Plan and UnitedHealthcare Community Plan. The new QUEST procurement went into effect on July 1, 2012.

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

- Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
- Financial incentives for improving quality to their members;

- Integration of medical and behavioral health services;
- Auto-assign algorithm based upon quality instead of cost; and
- Standardization of capitation payments amongst health plans.

MQD will report on the progress of these initiatives in the upcoming reports to CMS.

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

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

- **Implementation of revised Quality Strategy.**

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

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

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

MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. Results of the implementation of this program during the demonstration year are provided below:

	AlohaCare	HMSA	Kaiser
Childhood Immunization (HEDIS 2010)	No	No	Yes
Chlamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	\$0.40	\$0.40	\$0.80

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

## **Information about the Demonstration**

### **Overview and Brief History of the Demonstration**

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

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

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

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

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

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

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

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

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

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

## **Population Groups Impacted**

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

- Pregnant women in families whose income is up to 185 percent of the FPL.
- Infants and children in families whose income is up to 300 percent of the FPL.
- Adults and families with dependent children whose income is up to 100 percent of the FPL.
- Childless adults whose income is up to 100 percent of the FPL.
- Uninsured individuals in general.

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

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

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

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

## **Purpose, aims, objectives, and goals of the demonstration**

### ***Goals and Objectives of the Demonstration***

The goals and objectives of the demonstration include:

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

### ***Hypotheses on the Outcomes of the Demonstration***

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

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.
- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.

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

- Home and Community Based Service (HCBS) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.

### ***Key Interventions Planned***

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

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

## Evaluation Design

### Management and Coordination of Evaluation

#### *Organization Conducting the Evaluation*

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

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

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

#### *Timeline for Implementation of the Evaluation and for Deliverables*

##### Summary of Timeline for Annual Quality Activities

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

### Summary of Timeline for Biennial Quality Activities

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

### Summary of Timeline for Annual Deliverables

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

### Summary of Timeline for Compilation of Demonstration Evaluation Report

July	Analyze data from previous demonstration years
August	Compile information into report
September	Submit report

## Performance Metrics

### Summary of Performance Metrics

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

Measures	Reported Years	Latest Score	Target Score
<b>HEDIS Measures:</b>			
Use of Appropriate Medications for People With Asthma, Total (ASM)	HEDIS 2008-2012	75.6%	90.5%
Eye Exam (CDC)	HEDIS 2008-2012	59.4%	63.7%
HbA1c Testing (CDC)	HEDIS 2008-2012	81.2%	87.1%
HbA1c Control <7.0% (CDC)	HEDIS 2008-2012	24.2%	41.3%
Poor HbA1c Control >9% (CDC) #	HEDIS 2008-2012	52.8%	34.9%
LDL-C Screening (CDC)	HEDIS 2008-2012	77.2%	80.3%
LDL-C Level <100 mg/dL (CDC)	HEDIS 2008-2012	34.0%	41.4%
Medical Attention for Nephropathy (CDC)	HEDIS 2008-2012	79.0%	82.5%
Blood Pressure Controlled <140/80 mm Hg (CDC) *	HEDIS 2008-2012	36.2%	44.2%
LDL-C Screening (CMC)	HEDIS 2008-2012	81.0%	85.9%
LDL-C level <100 mg/dL (CMC)	HEDIS 2008-2012	41.7%	50.0%
Controlling High Blood Pressure (CBP)	HEDIS 2008-2012	47.1%	63.7%
Child Immunizations Status, Combination 2 (CIS)	HEDIS 2008-2012	61.9%	80.7%
Breast Cancer Screening (BCS)	HEDIS 2008-2012	49.7%	57.4%
Cervical Cancer Testing (CCS)	HEDIS 2008-2012	63.7%	74.2%
Chlamydia Screening (CHL)	HEDIS 2008-2012	58.2%	63.4%
Emergency Department Visits, per 1,000 member months, Total (AMB) @	HEDIS 2008-2012	43.0	44.4
<b>EPSDT Measures:</b>			
Screening Ratio	FFYE 2007-2011	0.98	0.82
Participant Ratio	FFYE 2007-2011	0.78	0.64
<b>CAHPS Measures:</b>			
Rating of Health Plan	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.51 QExA: 2.25	2.61
Rating of Personal Doctor	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.53 QExA: 2.54	2.65
Rating of Specialist Seen Most Often	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.48 QExA: 2.43	2.60
How Well Doctors Communicate	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.65 QExA: 2.57	2.70
Getting Needed Care	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.26 QExA: 2.23	2.43
Getting Care Quickly	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.29 QExA: 2.30	2.65
<b>Physicians' Assessment Measures</b>			
Attitude toward Hawaii Med-QUEST	2009, 2011	34.7%	N/A
Satisfaction with reimbursement from the Med-QUEST health plan	2009, 2011	26.4%	N/A
Does the health plan personnel have the necessary professional knowledge	2009, 2011	24.8%	N/A
Impact of the health plan's UM (prior authorizations) on quality care	2009, 2011	19.1%	N/A
<b>Med-QUEST Internal Measures</b>			
HCBS % of Nursing Home Population	2008 - 2012	68.5%	N/A
Cumulative Savings from Increase in HCBS Population	2008 - 2012	\$80,123,000	N/A
Medicaid Enrollment	2008 - 2012	287,902	N/A
Budget Neutrality Savings	DY 18	\$1,833,414,530	> 0

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

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

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

### ***Population Groups of Enrollees for which Data will be Analyzed***

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

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

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

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

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

### **Integration of the State Quality Improvement Strategy**

The MQD started working with CMS, with Gary Jackson as the contact, in January 2010 on the revision of the Quality Strategy. MQD followed the CMS toolkit and checklist for State Quality Strategies as well as the Delaware Quality Strategy as a template. In May 2010, MQD submitted the revised Quality Strategy to CMS. The public comment period ended on September 9, 2010 and MQD received approval of its Quality Strategy. A copy of the Quality Strategy is posted at the MQD website ([www.med-quest.us](http://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. As MQD evaluates the demonstration, the Quality Strategy is used as the framework for the evaluation.

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

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

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

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

## Measures

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

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

### HEDIS Measures

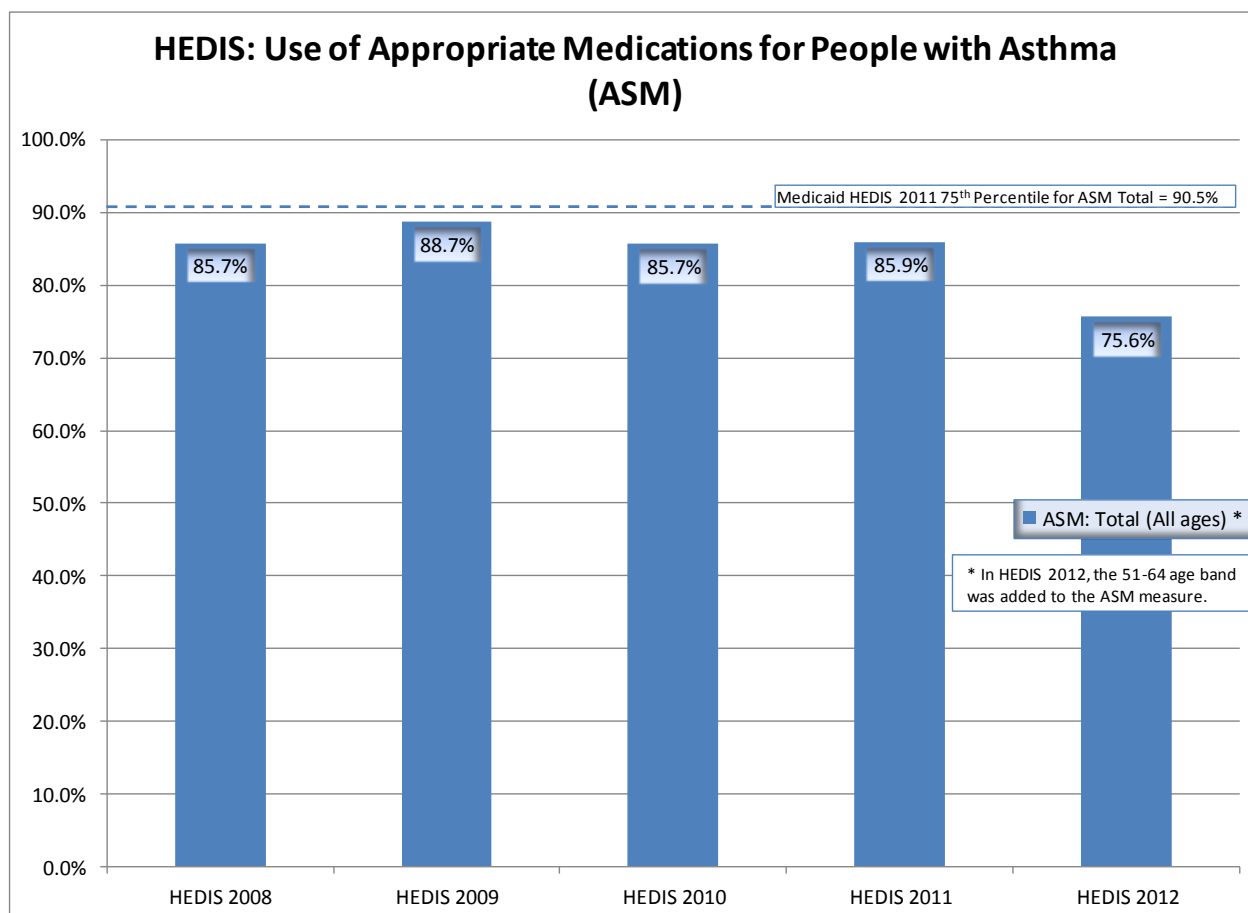
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST and QExA plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan, and UnitedHealth 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 2012. A comparison is made to the 2011 National Medicaid Median 75<sup>th</sup> Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75<sup>th</sup> 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.

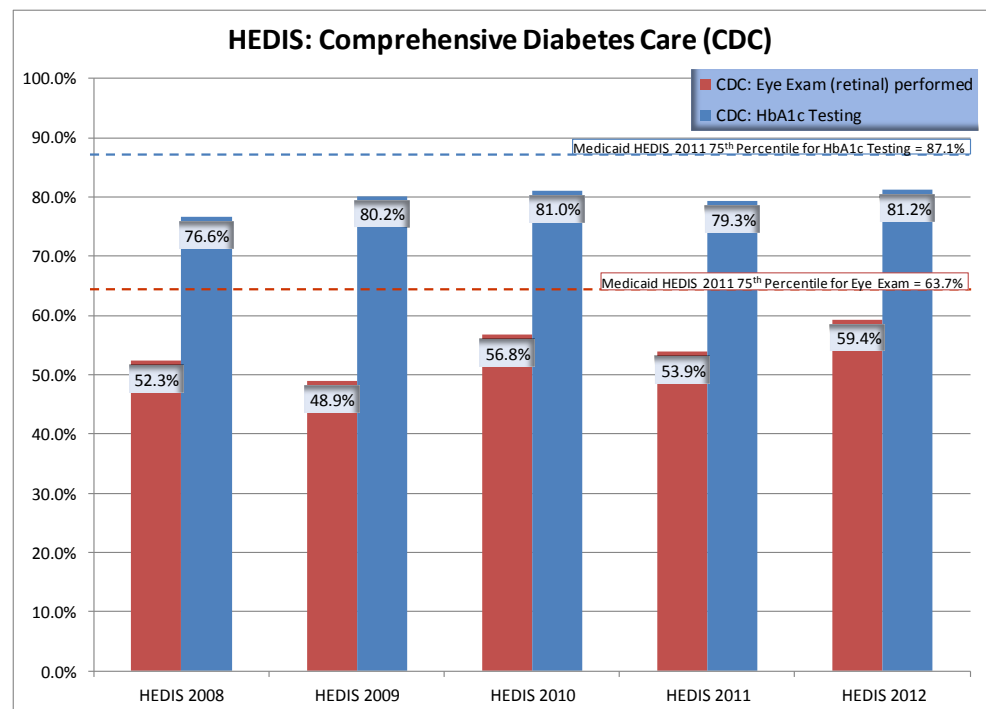


#### ASM:

- 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 2012, 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 increased the 2012 score past 76.0%.
- The 2012 year's score fell significantly from the previous four-year range between 85% and 88%, clearly falling out of the historical trend for this measure on the negative side.
- The HI Quality Strategy target percentage for the ASM measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 90.5%, which was better than all of the 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 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.



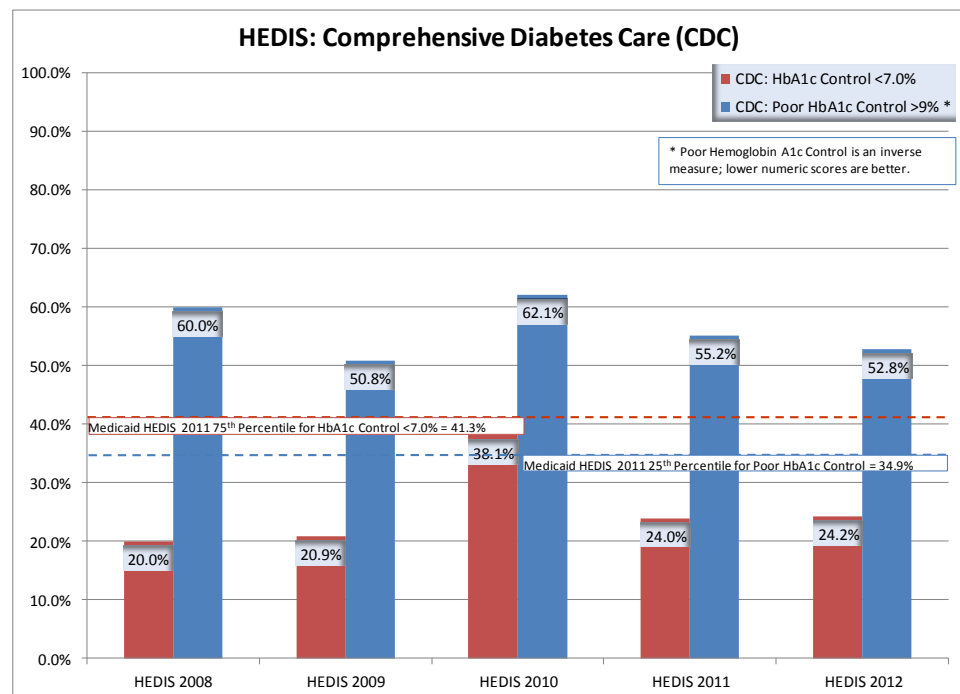
- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 63.7%, which was better than all of the years reported.

## CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 82% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.
- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 87.1%, which is above all of the years reported.

## CDC – HbA1c Control <7.0%:

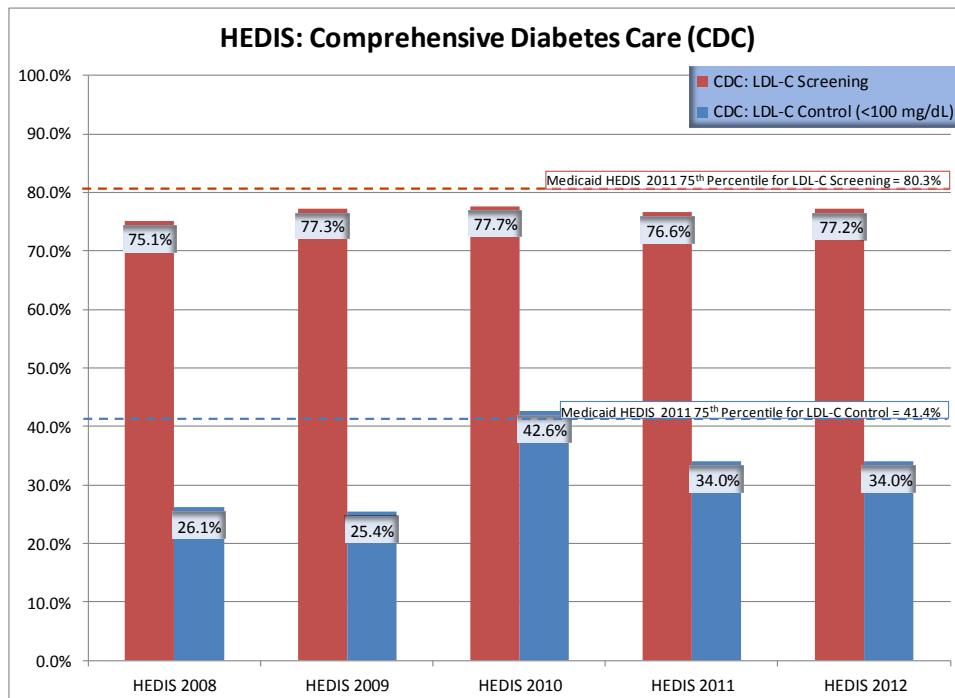
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under good control varied between 20% and 39% from 2008 to 2012, with the highest rate of 38.1% occurring in 2010 and the lowest rate of 20.0% occurring in 2008.



- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the earliest year (2008) reported the lowest rate. There is what seems like an outlier score in 2010 of 38.1%, especially when considering the four other years' scores were bunched between 20.0% and 24.2%
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 41.3%, which is above all of the years reported.

## CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 50% from 2008 to 2012, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 50.8% occurring in 2009. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a slight downtrend (good) to flat trend in the rates of the five years reported. The last three years' score went from 62.1% to 55.2% to 52.8%, yet the lowest score occurred in 2009 (50.8%).
- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25<sup>th</sup> percentile of the national Medicaid population. For the 2011 this target was 34.9%, which is below (not good) all of the years reported.



#### CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 78% from 2008 to 2012, with the highest rate of 77.7% occurring in 2010 and the lowest rate of 75.1%

occurring in 2008.

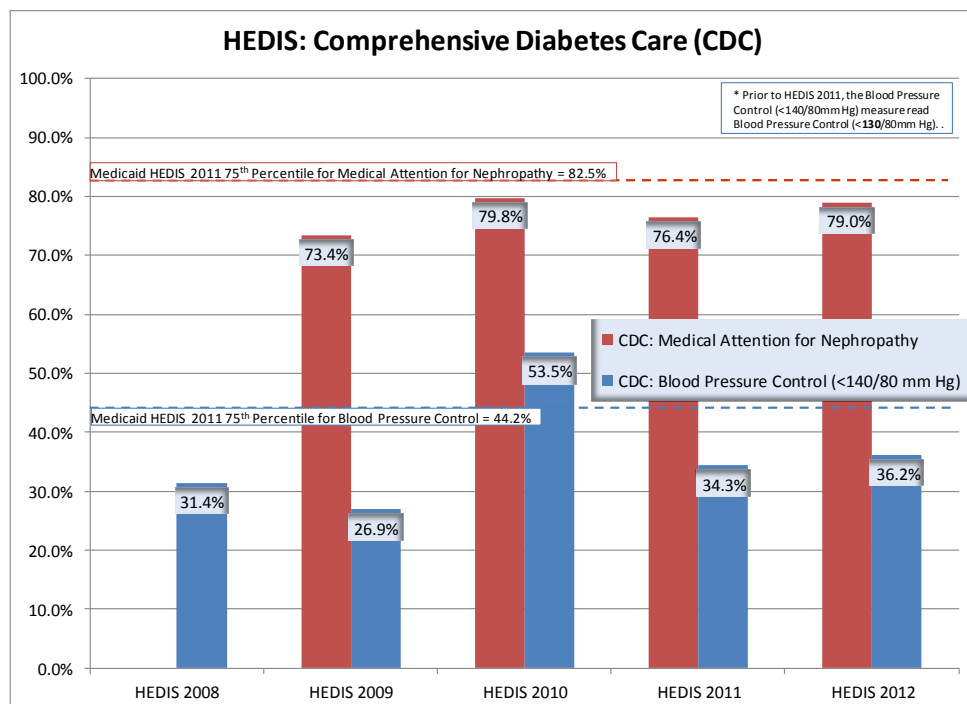
- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which 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 2012, 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 five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

## CDC – Medical Attention for Nephropathy:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 80% from 2009 to 2012, with the

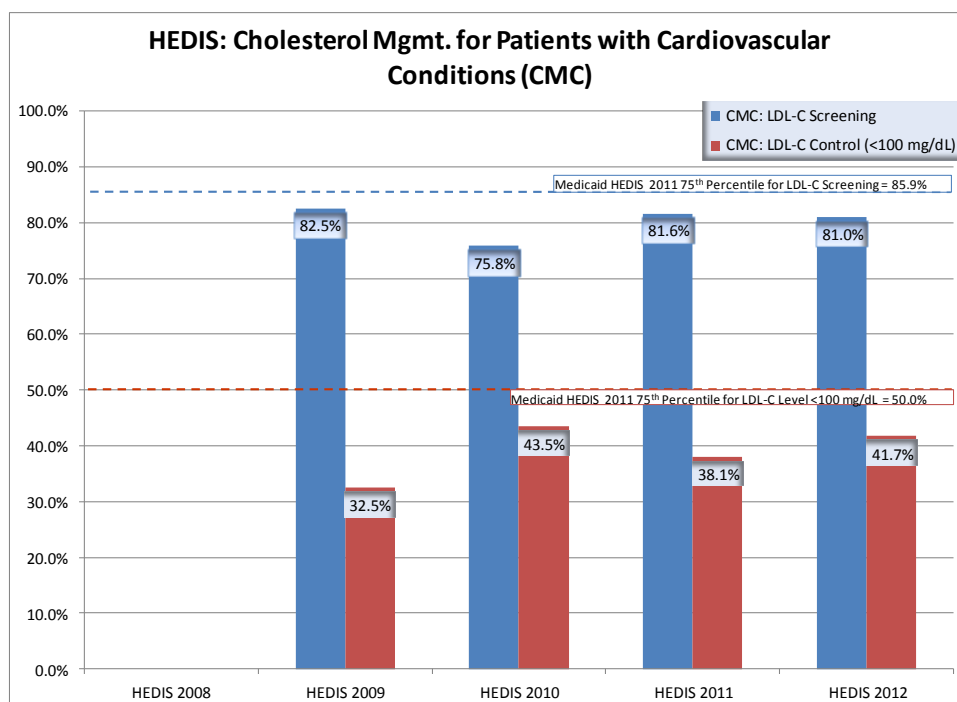


highest rate of 79.8% occurring in 2010 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.

- There is a slight up trend in the rates of the four years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2012) had a rate (79.0%) not much lower than the 79.8% in 2010.
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 this target was 82.5%, which is higher than all of the years reported.

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

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2012, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.
- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2011 (34.3%) and 2012 (36.2%).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 44.2%, which is higher than all of the years reported except for in 2010.



### CMC – LDL-C Screening:

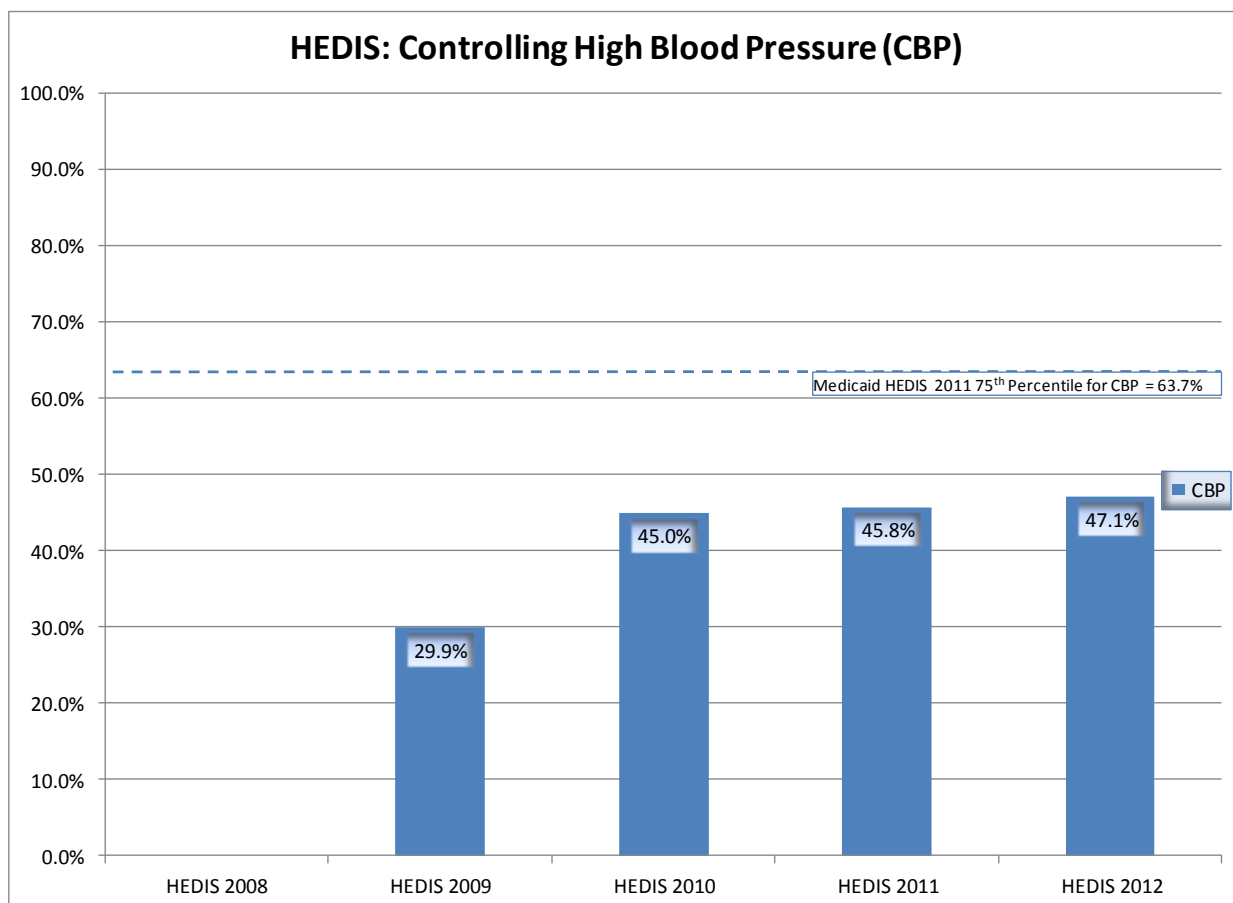
- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 82% from 2009 to 2012, with the highest rate of 82.5% occurring in 2009 and the lowest

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

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first year (2009), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 85.9%, which is higher than all of the years reported.

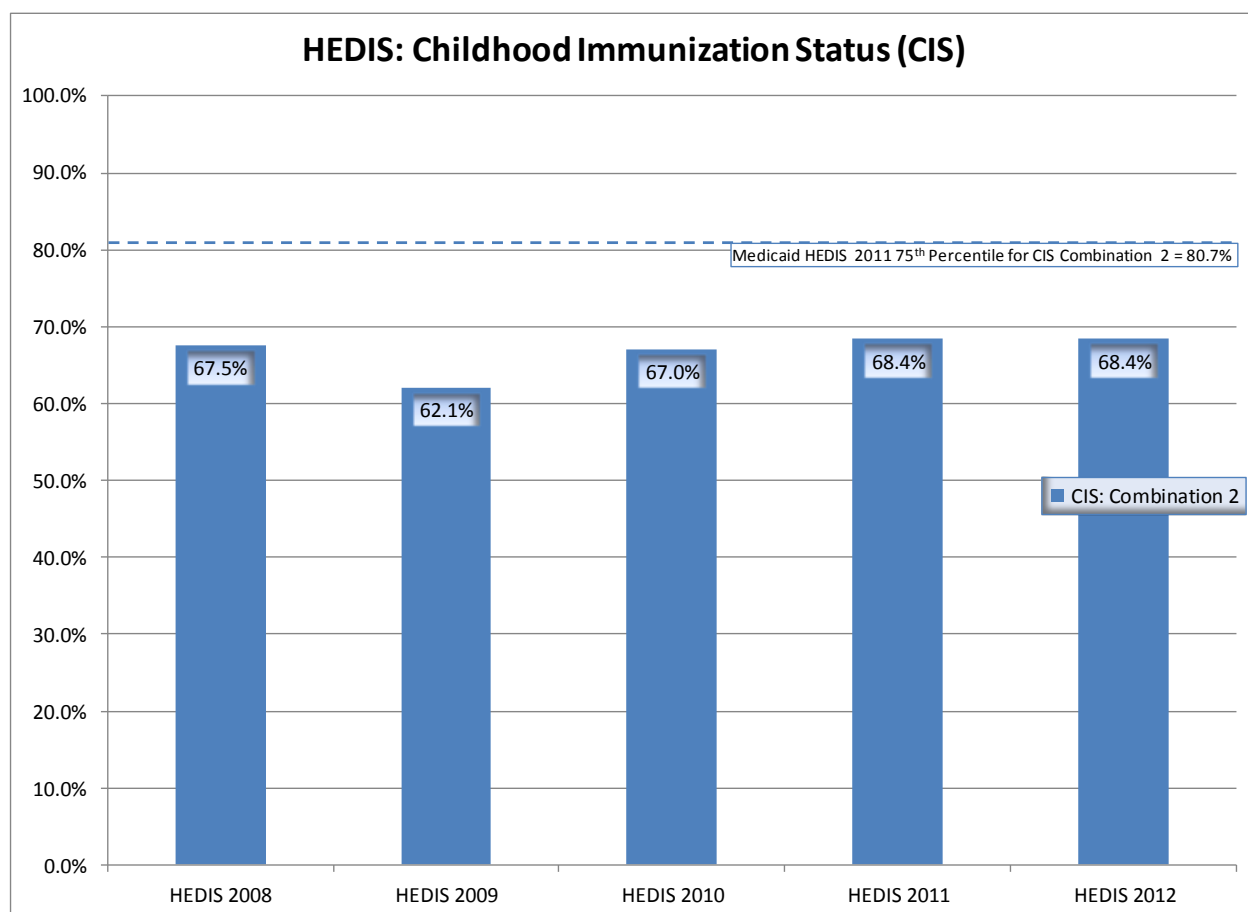
### CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 43% from 2009 to 2012, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.
- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010, the highest two scores were in 2011 (38.1%) and 2012 (41.7%).
- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 50.0%, which is higher than all of the years reported.



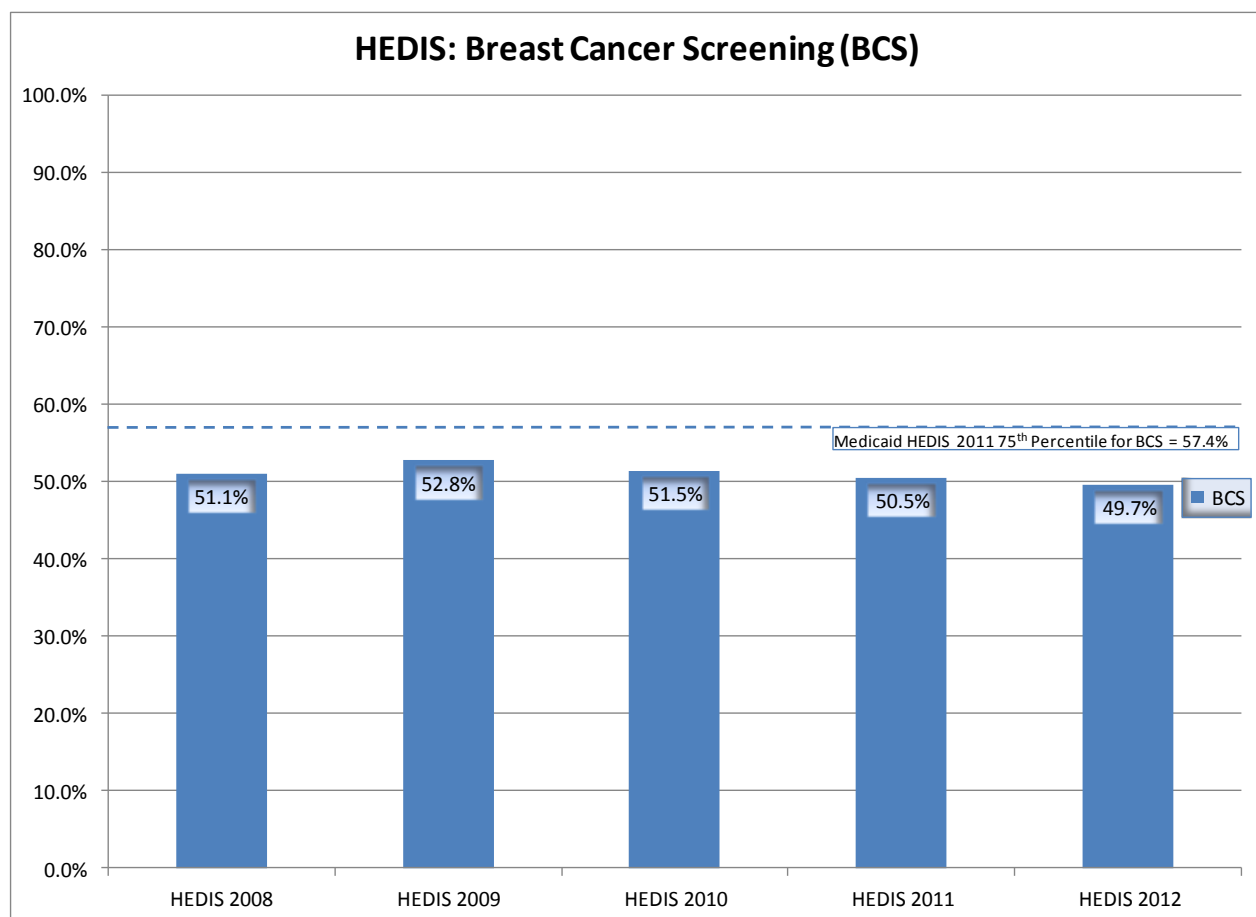
#### CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 48% from 2009 to 2012, with the highest rate of 47.1% occurring in 2012 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.
- There is a clear up trend in the rates of the five years reported. From 2009 thru 2012, each subsequent year's score is higher than the last.
- The HI Quality Strategy target percentage for the CBP Control measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.7%, which is higher than all of the years reported.



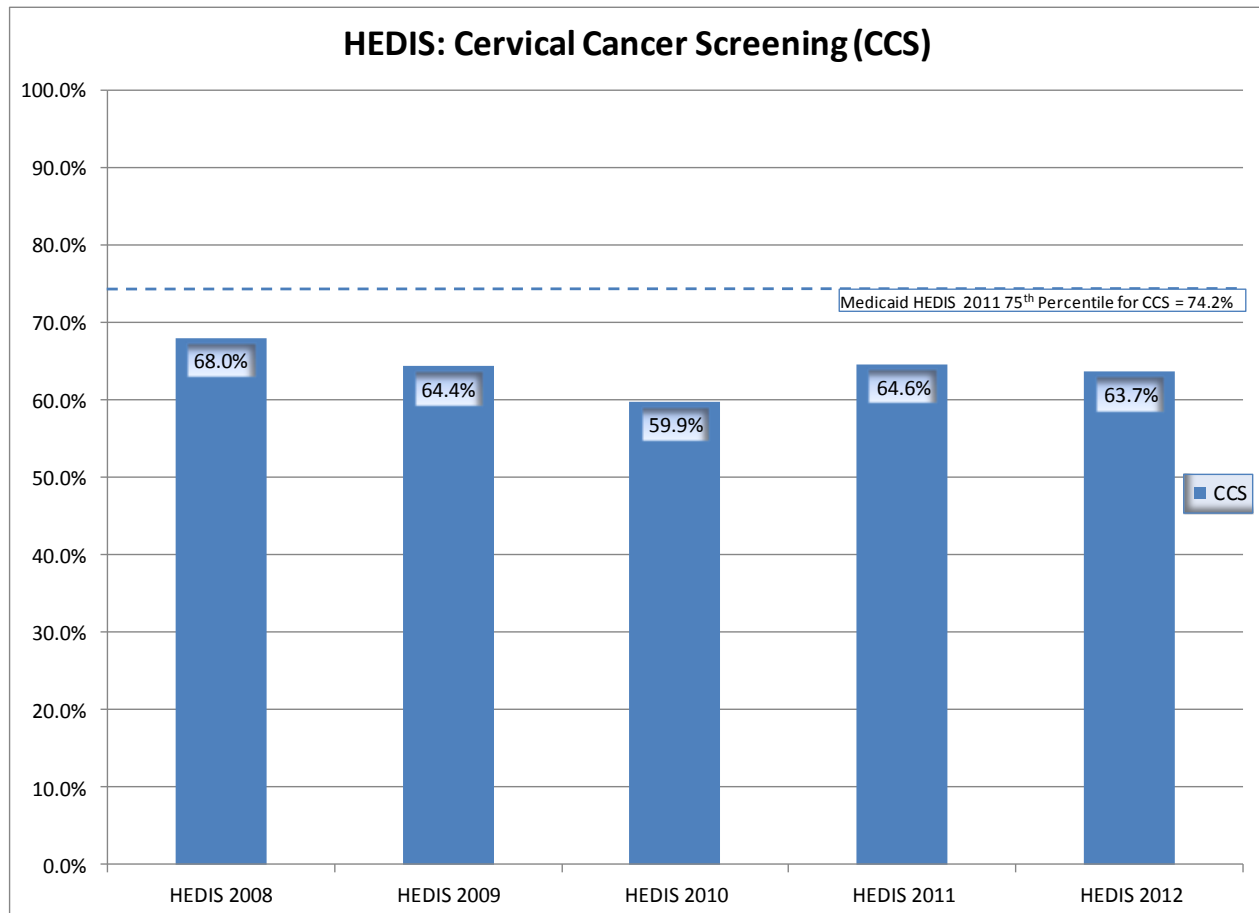
#### CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 69% from 2008 to 2012, with the highest rate of 68.4% occurring in 2011 & 2012 and the lowest rate of 62.1% occurring in 2009.
- There is a slight up trend in the rates of the five years reported. Excluding the 2008 rate, the rates increased from 2009 to 2012 by 4.1 percentage points with not yearly decreases.
- The HI Quality Strategy target percentage for the CIS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 80.7%, which is higher than all of the years reported.



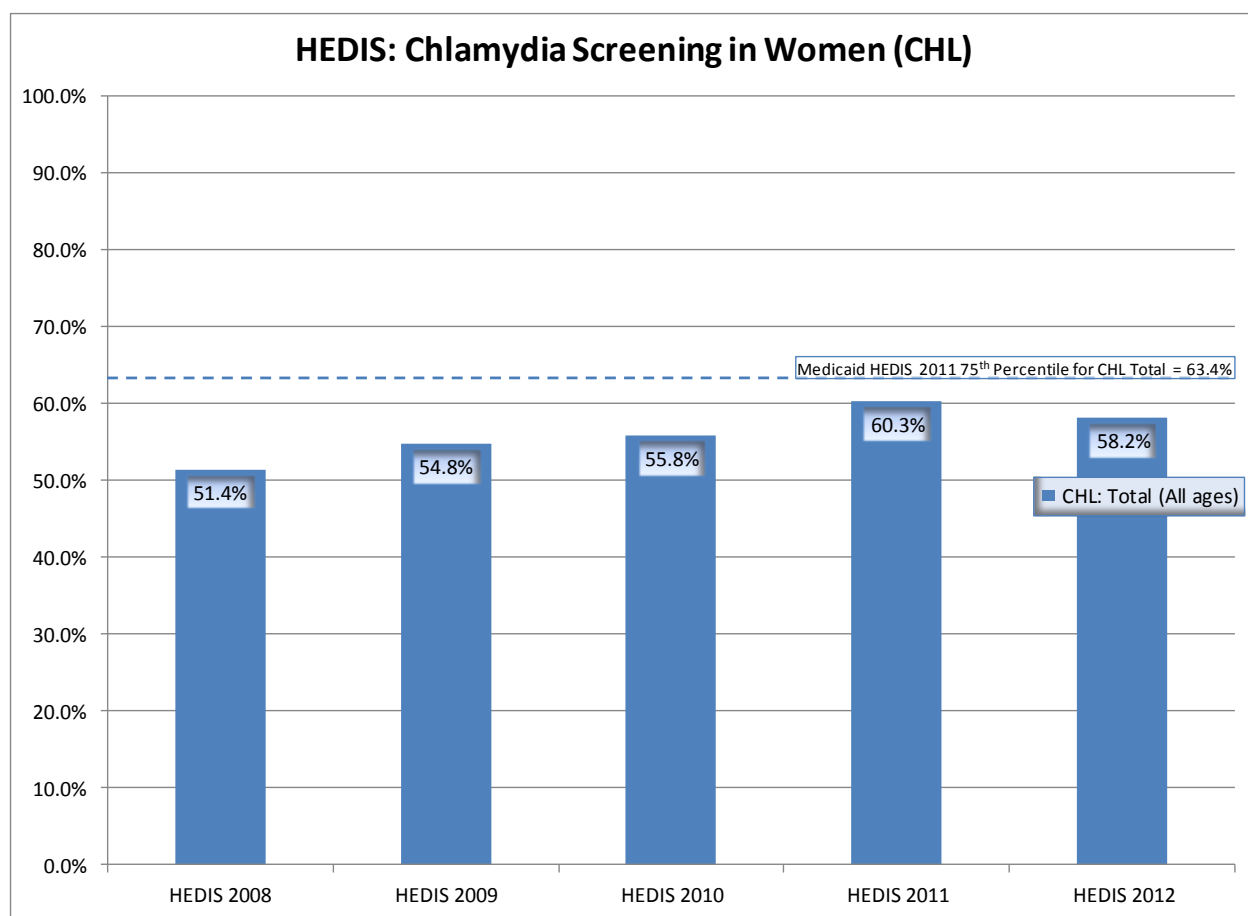
#### BCS:

- 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 2012, 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 of the five years reported. Removing the 2008 score, the rates go consistently down approximately 1% per year from 52.8% (2009) to 49.7% (2012).
- The HI Quality Strategy target percentage for the BCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 57.4%, which is higher than all of the years reported.



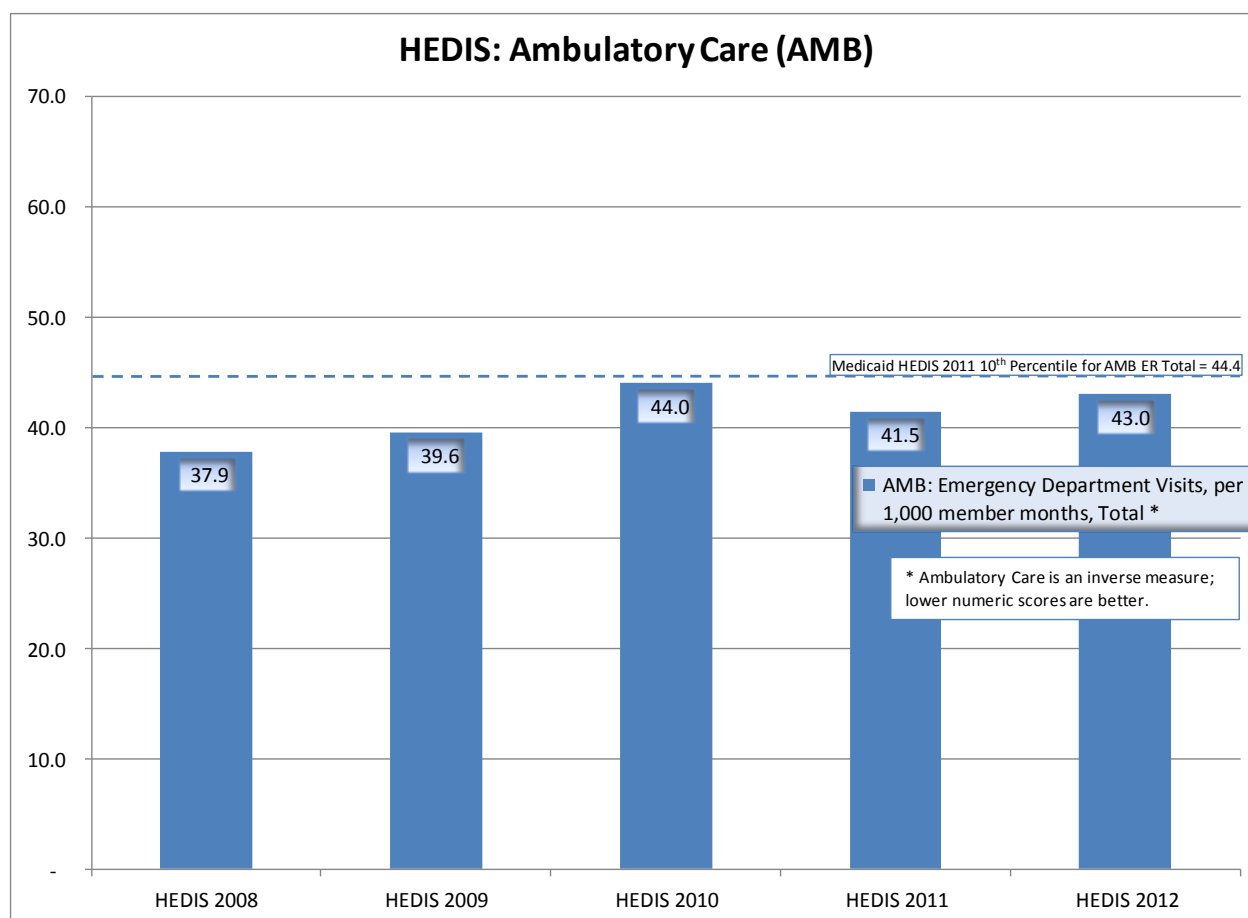
#### CCS:

- 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 2012, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.
- There is a slight down trend in the rates of the five years reported. Removing the middle 2010 score, the highest rate (68.0%) is in 2008 and the lowest rate (63.7%) is in 2012.
- The HI Quality Strategy target percentage for the CCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 74.2%, which is higher than all of the years reported.



#### CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 61% from 2008 to 2012, with the highest rate of 60.3% occurring in 2011 and the lowest rate of 51.4% occurring in 2008.
- There is a clear up trend in the rates of the five years reported. Removing the most recent score, the lowest rate (51.4%) is in 2008 and the highest rate (60.3%) is in 2011.
- The HI Quality Strategy target percentage for the CCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.4%, which is higher than all of the years reported.



#### AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2012, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a clear up trend (bad) in the rates of the five years reported. Putting aside the high rate in 2010, the lowest rate (37.9) occurred in 2008, and the highest rate (43.0) occurred in 2012.
- The HI Quality Strategy target percentage for the CCS measure is the 10<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 44.4, which is higher (good) than all of the years reported.

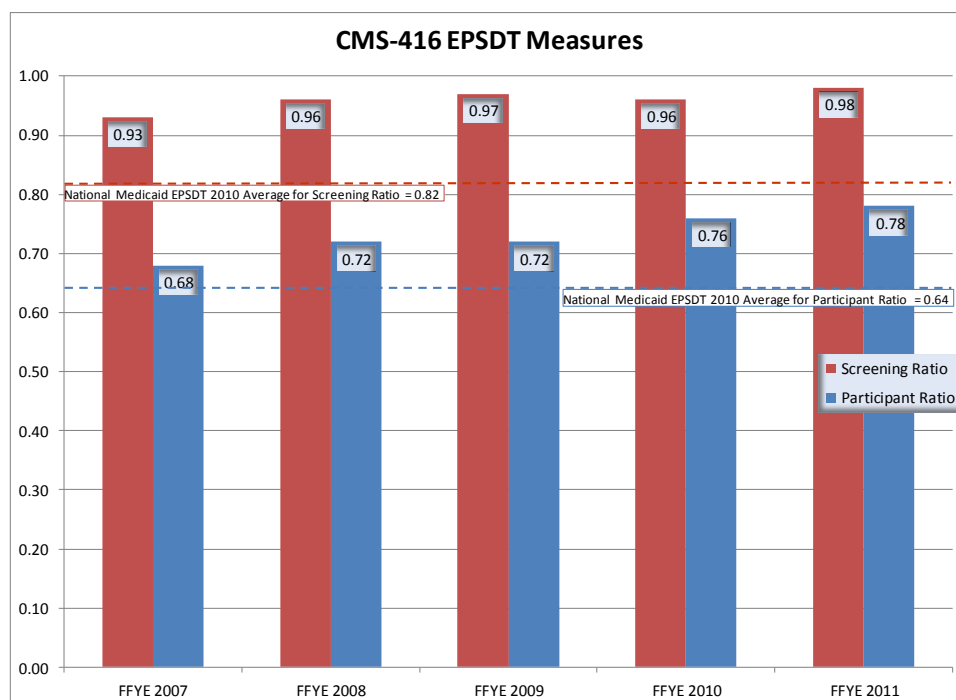
## EPSDT Measures

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 UnitedHealth 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 2011. A comparison is made to the National Medicaid EPSDT Average score – the 50<sup>th</sup> 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 0.98 from 2007 to 2011, with the highest rate of 0.98 occurring in 2011 and the lowest rate of 0.93 occurring in 2007.

- There is a clear up trend in the rates of the five

years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.98 was reported in the last year (2011), with a mostly steady uptrend in between.

- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2010 – 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 five 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 2010 – the latest reported year – then national average is 0.64, 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.

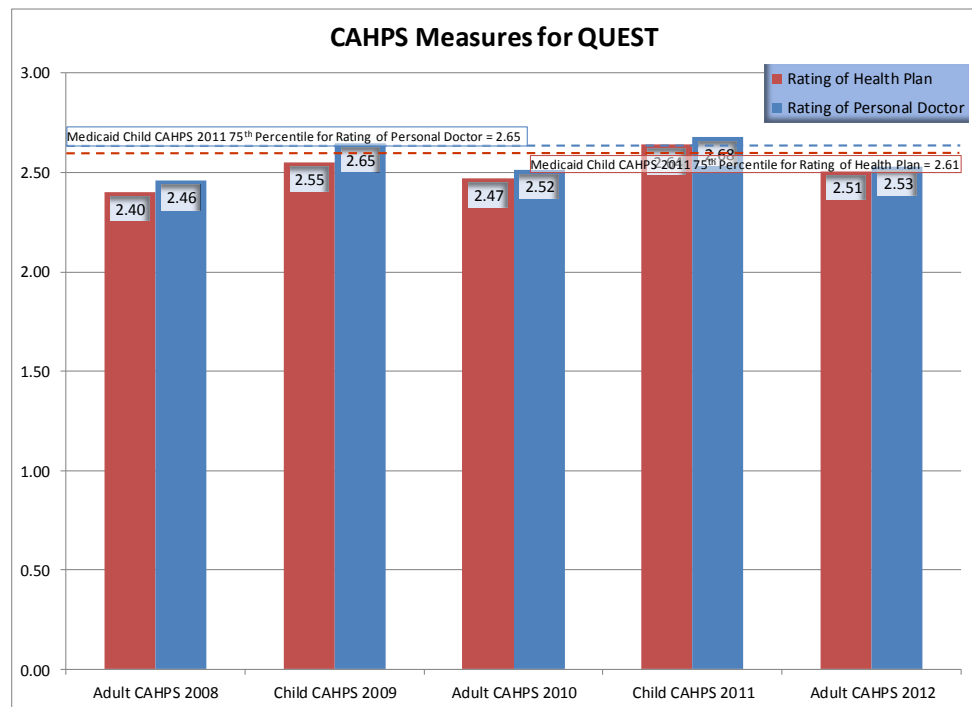
Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures 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 and 38% in 2012. The “question summary rates” are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010 & 2012, and the Child Medicaid survey was done in 2009 & 2011. All five 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 2011 75<sup>th</sup> percentile score to bring perspective to where we score on a national level; at the time of this report the National Medicaid Child CAHPS 2012 percentile scores were not available. The National Medicaid 75<sup>th</sup> 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:

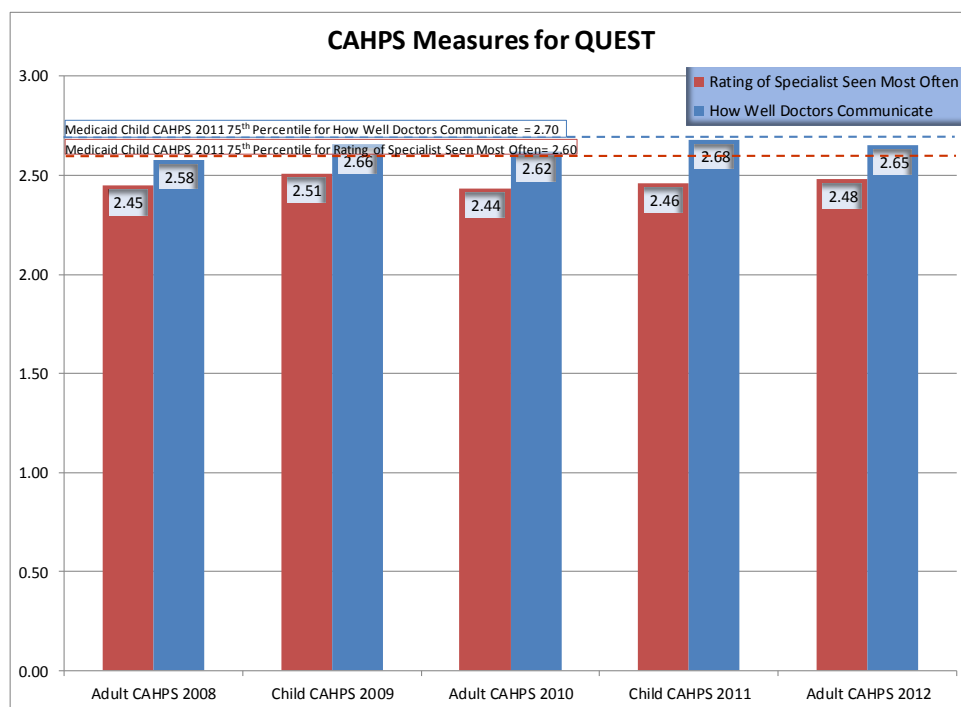
- The statewide CAHPS – Rating of Health Plan for the QUEST population varied between a high rate of 2.64 occurring in 2011 and the lowest rate of 2.40 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show a similar pattern, moving from 2.55 to 2.64.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.61, which was exceeded by the 2.64 rate reported in 2011.

## CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a similar pattern, moving from 2.65 to 2.68.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was exceeded by the 2.68 rate reported in 2011.



### 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 five years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46.
- The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which 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.

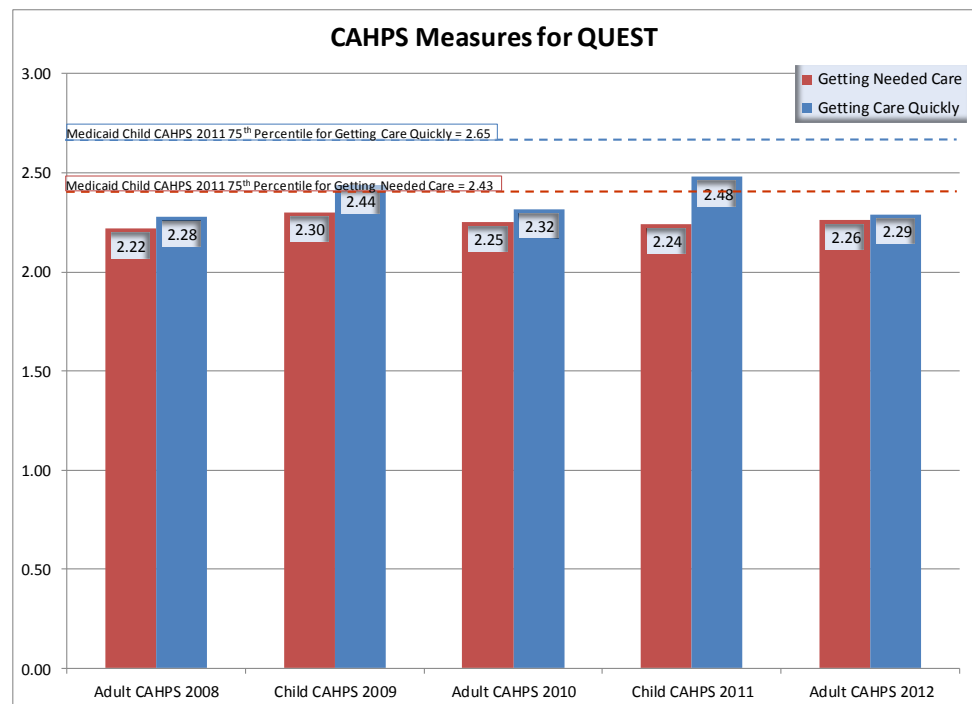
### CAHPS for QUEST – How Well Doctors Communicate:

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

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which 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:

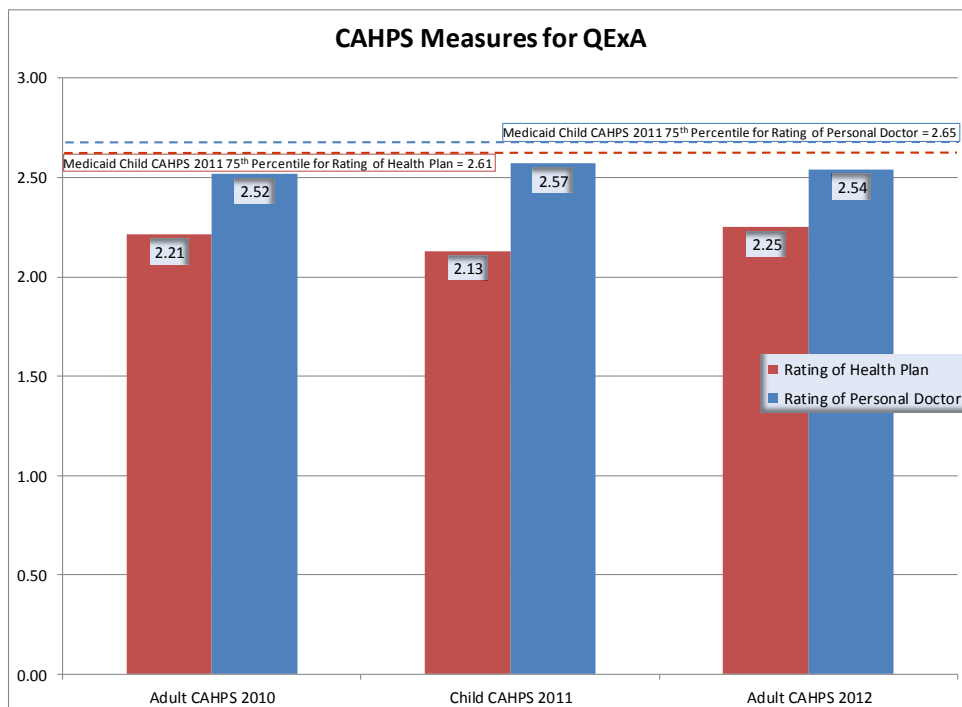
- The statewide CAHPS – Getting Needed Care for the QUEST population varied between a high rate of 2.30 occurring in 2009 and the lowest rate of 2.22 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern, moving from 2.30 to 2.24.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was higher than all of the reported year.

### CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.48 occurring in 2011 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which 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 2.25 occurring in 2012 and the lowest rate of 2.13 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child. Also note

that the QExA program began in February 2009, which limits the number of data points.

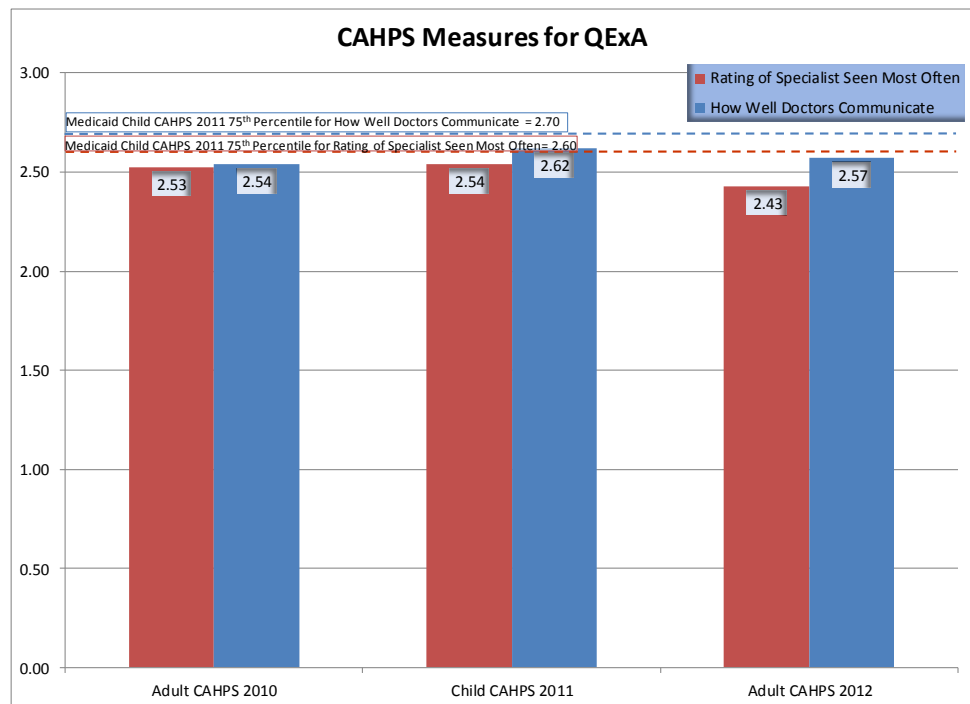
- There is a flat trend in the rates of the three years reported. The low point in 2011 was the only data point for the Child population.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year this target was 2.61, which was better than all reported rates.

#### CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.57 occurring in 2011 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the three years reported. All years lie within a 0.05 point window.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported years' rates.

CAHPS for QExA  
– Rating of  
Specialist Seen  
Most Often:

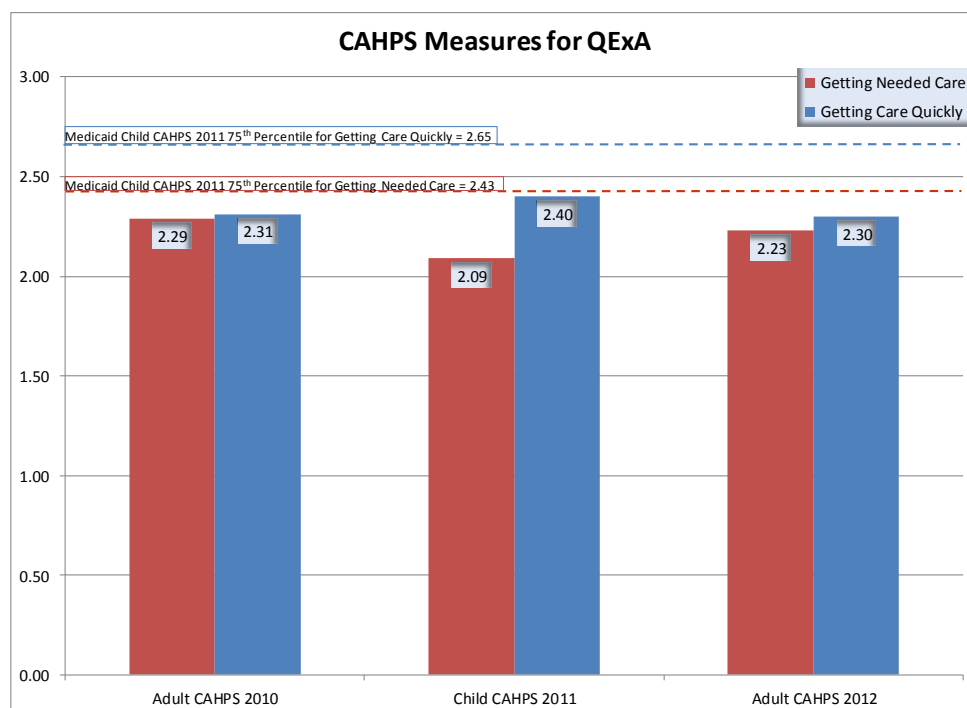
- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.54 occurring in 2011 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.



- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.62 occurring in 2011 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no trend in the rates of the three years reported. Removing the Child year in 2011, the Adult score moves from 2.54 to 2.57 from 2010 to 2012.
- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was 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 2.29 occurring in 2010 and the lowest rate of 2.09 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was above each of the reported years.

#### CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.40 occurring in 2011 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was 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.

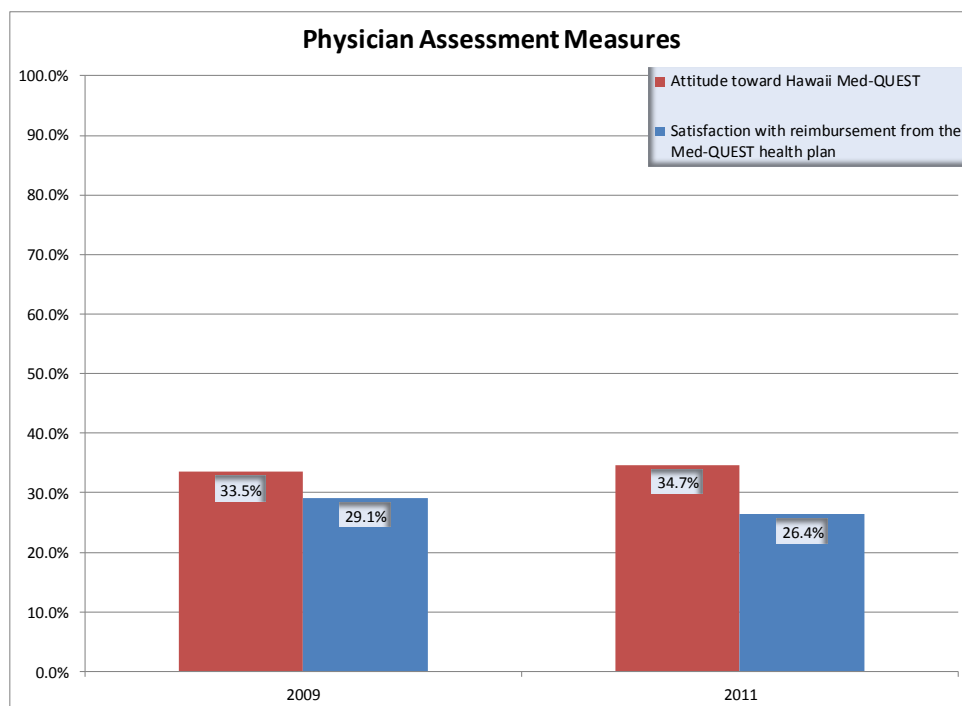
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall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

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

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

### Physician Assessment – Attitude Toward Hawaii Med-QUEST:

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



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

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

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

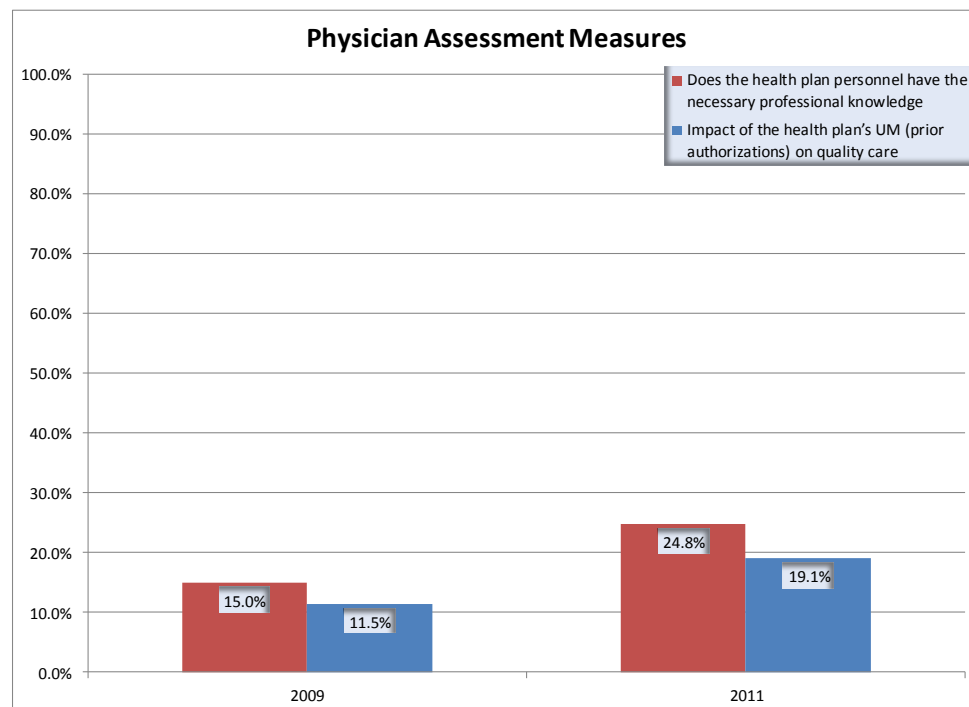
- The statewide Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan went from 29.1% in 2009 down to 26.4% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment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

#### Physician Assessment – Necessary Professional Knowledge:

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

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

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



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

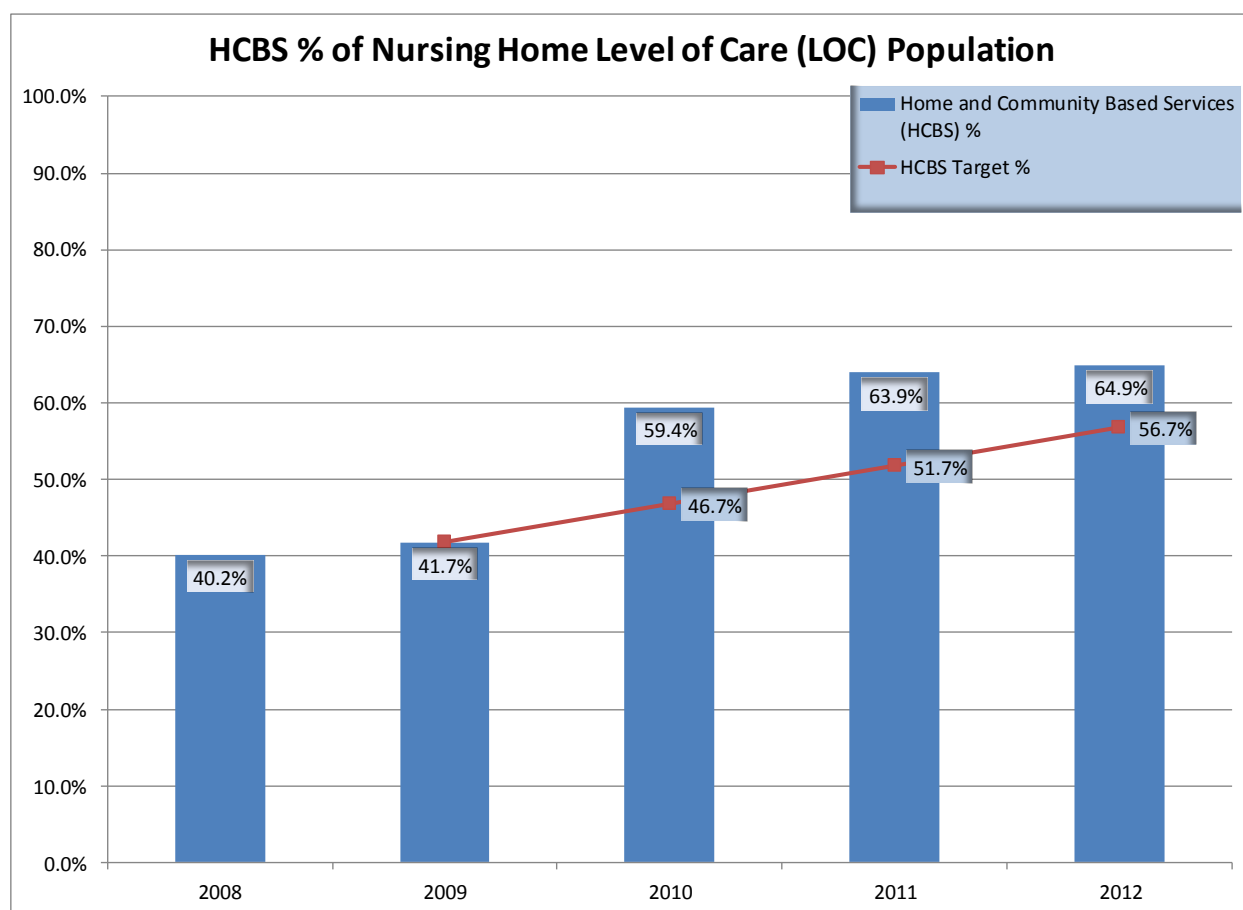
- The statewide Physician Assessment – Impact of the health plan's UM went from 11.5% in 2009 down to 19.1% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

## **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.

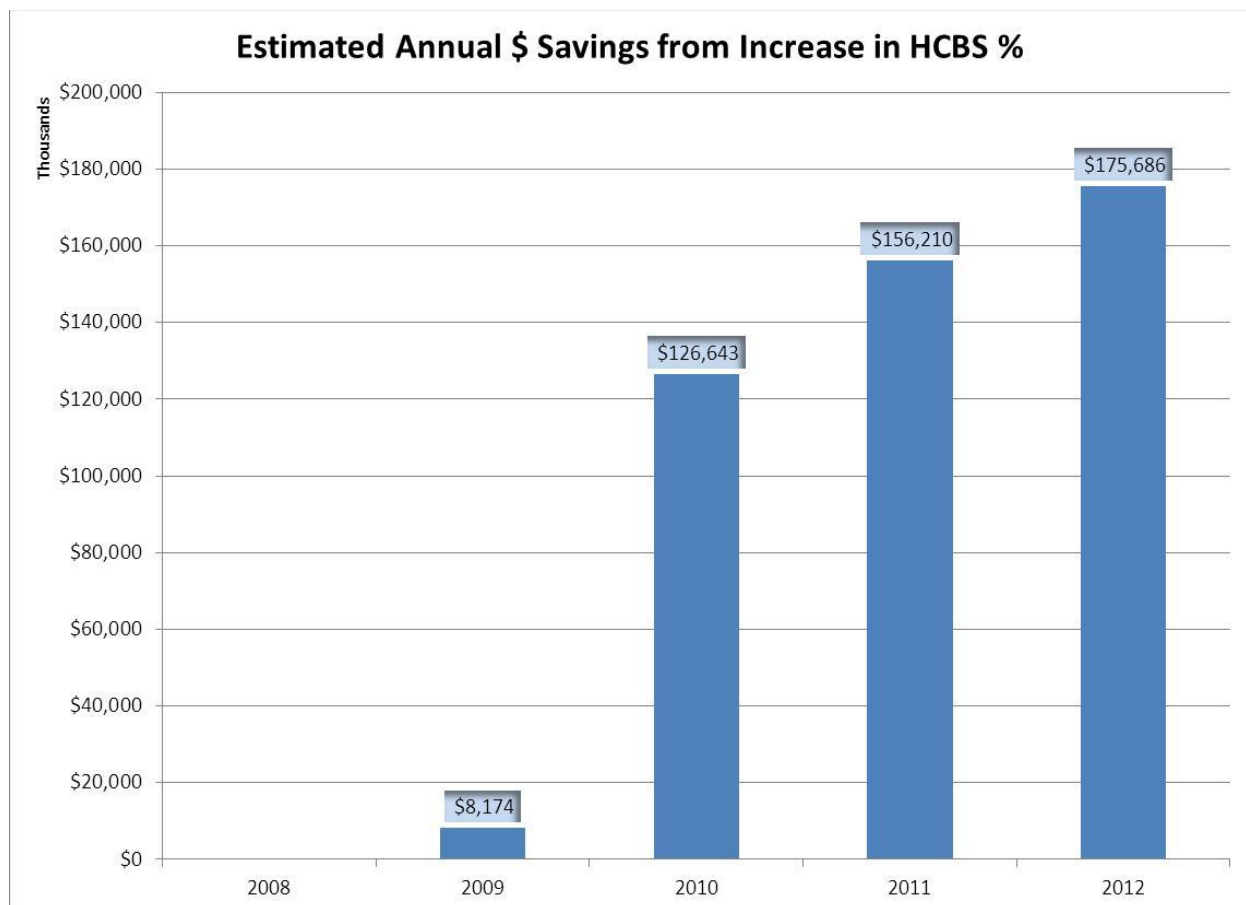
The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is 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 \$6,194.86 in calendar year 2011. We look at both the increase in HCBS % of the total nursing home LOC population as well as the MQD's cumulative annual dollars saving from this increase in HCBS %. The cumulative dollar savings is calculated by determining taking the difference between the current year's HCBS % and the 2009 HCBS%, multiplying it by the total nursing home LOC population to get a monthly savings figure, and then multiplying it by twelve to get an annual savings figure.

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



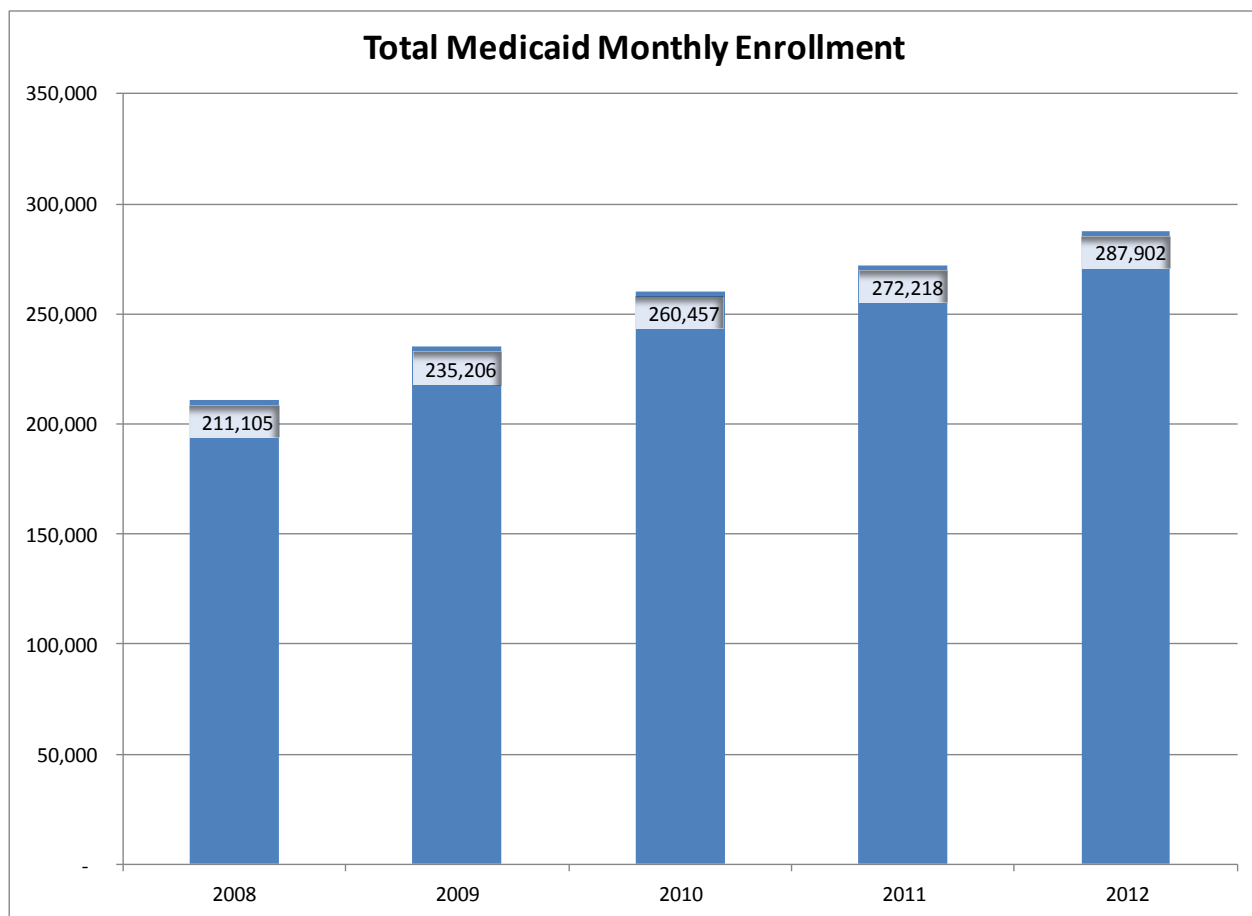
#### HCBS % of Nursing Home LOC Population:

- The statewide HCBS % of Nursing Home LOC Population went from 40.2% in 2008 to 64.9% in 2012.
- There is a clear upward trend in the rates. The QExA program began in February of 2009, and the largest percentage jump occurred between 2009 and 2010.
- Our Quality Strategy sets as a target a 5% per year increase in the HCBS % for our QExA program. Since beginning in February 2009 to the current year, this goal has been exceeded in each year.
- Prior to July 2010, the MQD had a fiscal incentive for the QExA health plans to move nursing home LOC clients from an institutional setting to a HCBS setting, which involved different capitation payments for HCBS vs. institutional settings. Beginning July 2010, the QExA health plans were paid a composite (average) capitation payment for all nursing home LOC clients, which changed the method of financial incentive in moving clients into an HCBS setting. This would explain the flattening off of the increases in percentage of clients that are in an HCBS setting.



**Estimated Annual \$ Savings from Increase in HCBS %:**

- The statewide Estimated Annual \$ Savings from Increase in HCBS % went from \$8,174,000 in 2009 to \$175,686,000 in 2012. The 2011 actual differential in \$ pmpm cost between institutional care and HCBS care is \$6,194.86, and this was used in the calculation of cost savings.
- Following the clear upward trend in the HCBS %, there is a corresponding cumulative increase in the dollars saved from this transition to HCBS.
- There is no National average available for dollars saved based on the move to HCBS.



**Total Medicaid Monthly Enrollment:**

- The statewide Total Medicaid Monthly Enrollment went from 211,105 in 2008 to 287,902 in 2012, which equates to an average annual increase of 5.8%.
- There is a clear upward trend in Medicaid enrollment, with each year logging consistent gains.
- There is no National average available for annual Medicaid enrollment increase.
- The Hawaii economy and unemployment rate continue to hover above 2008 pre-recession levels, causing the Hawaii Medicaid enrollment to continue to rise.
- With implementation of the Affordable Care Act (ACA), MQD does not expect a decrease of enrollment.

## Budget Neutrality Savings

Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the “With Waiver” expenditures are less than the “Without Waiver” expenditures, then Budget Neutrality Savings will result. The following table details the budget neutrality calculation through Demonstration Year 18 (DY18) of the 1115 waiver. The overall total computable savings is \$1,833,414,530. An additional version of the Budget Neutrality information is found in Appendix A.

Hawaii 1115 QUEST Waiver TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal/Extension			Renewal			
WITHOUT WAIVER	FMAP	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
	MEG Description and Comments	58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
		58.81%	57.55%	56.50%	67.35%	54.24%	62.63%	50.48%
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	\$261.16	\$281.11	\$302.59	\$322.62	\$343.98	\$366.75	\$391.03
	TANF Adults	\$458.35	\$493.37	\$531.07	\$564.90	\$600.88	\$639.18	\$679.87
	Aged				\$1,204.63	\$1,281.84	\$1,364.01	\$1,451.44
	Blind/Disabled				\$1,489.42	\$1,597.11	\$1,712.58	\$1,836.40
Member Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	1,282,911	1,261,533	1,193,278	1,540,890	1,994,062	2,130,996	2,166,975
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	\$402,056,806	\$424,960,513	\$443,327,661	\$837,493,616	\$1,343,204,149	\$1,520,758,456	\$1,631,791,072
DSH		\$80,364,047	\$81,971,327	\$83,856,667	\$87,546,360	\$89,735,019	\$91,350,249	\$94,547,507
Total Ceiling		\$482,420,853	\$506,931,840	\$527,184,328	\$925,039,976	\$1,432,939,168	\$1,612,108,705	\$1,726,338,579
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	\$0	\$0	(\$295)	\$121,310,557	\$314,957,371	\$350,728,888	\$330,293,296
	Aged w/o Mcare	\$0	\$0	\$0	\$2,424,989	\$17,555,107	\$24,896,097	\$19,060,304
	B/D w/Mcare	\$0	\$0	(\$13,736)	\$31,795,707	\$74,850,400	\$81,249,425	\$77,690,468
	B/D w/o Mcare	\$0	\$0	(\$28,991)	\$81,514,842	\$211,801,011	\$248,768,345	\$251,740,251
	Breast Cervical Cancer Treatment (BOCT)	\$0	\$0	\$0	\$0	\$4,051	\$545,195	\$734,188
	CURRENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	CURRENT POP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Current-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Demo Elg Adults	\$127,983,510	\$129,458,220	\$154,645,707	\$177,396,443	\$201,629,508	\$238,017,265	\$245,339,887
	FosterCare(19-20)	\$0	\$0	\$91,499	\$83,366	\$94,158	\$137,233	\$77,745
	Haw aii Quest-1902(R)(2)	\$0	\$0	\$33,061	\$26,332	\$0	\$0	\$0
	HCCP	\$0	\$0	\$135,520	\$683,159	\$0	\$0	\$0
	HealthQuest-Current	(\$2,325,152)	\$0	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Others	(\$621,643)	\$0	\$0	\$0	\$0	\$0	\$0
	Med Needy Adults	\$56,504	\$120,767	\$115,893	\$58,345	\$117,005	\$109,837	\$8,305
	Med Needy Children	\$0	\$0	\$0	\$7,715	\$3,960	\$0	\$0
	MFCP	\$0	\$0	\$122,839	\$581,513	\$0	\$0	\$0
	NH w/o W	\$0	\$0	\$5,100,418	\$16,199,737	\$0	\$0	\$0
	Opt St Pl Children	\$76,678	\$103,084	\$80,075	\$257,166	\$253,182	\$31	\$0
	Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Others-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	OthersX	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	QUEST ACE	(\$2,751)	\$798,681	\$5,696,094	\$14,353,208	\$23,872,001	\$30,434,166	\$28,884,029
	RAACP	\$0	\$0	\$7,862,479	\$17,432,949	\$0	\$0	\$0
	St Pl Adults-Preg Immig/OOFAs	\$0	\$0	\$0	\$0	\$24,990	\$2,622,138	\$2,718,679
	State Plan Adults	\$111,983,043	\$118,021,622	\$109,034,691	\$128,225,127	\$132,187,409	\$123,786,545	\$118,966,463
	State Plan Children	\$181,803,156	\$179,673,972	\$155,394,295	\$168,854,083	\$203,903,281	\$214,486,295	\$199,141,564
	Supp. - Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Supp. - State Gov.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	UCC-Governmental	\$15,688,221	\$22,546,108	\$18,919,184	\$16,356,580	\$24,507,605	\$34,064,491	\$40,634,690
	UCC-Private	\$10,056,500	\$3,403,710	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$0
		\$444,698,066	\$454,126,164	\$464,688,533	\$785,061,818	\$1,213,269,040	\$1,357,345,951	\$1,315,289,869
		-\$1,459,097	-\$1,189,919	-\$660,309	-\$4,962,002	-\$38,297,536	-\$43,476,661	-\$38,375,159
		\$443,238,969	\$452,936,245	\$464,028,224	\$780,099,816	\$1,174,971,504	\$1,313,869,290	\$1,276,914,710
		\$39,181,885	\$53,995,595	\$63,156,104	\$144,940,160	\$257,967,664	\$298,239,415	\$449,423,868
		\$565,691,724	\$619,687,319	\$682,843,423	\$827,783,582	\$1,085,751,247	\$1,383,990,662	\$1,833,414,530
		-\$334,903	-\$352,488	-\$217,644	-\$22,587	-\$15,945,497	-\$15,835,580	-\$10,164,390
		-\$323,973	-\$263,058	-\$239,466	-\$19,777	-\$6,517,946	-\$9,185,458	-\$9,300,862
		-\$347,005	-\$279,056	-\$147,219	-\$22,317	-\$9,503,023	-\$9,356,037	-\$9,335,080
		-\$453,216	-\$295,317	-\$55,980	-\$4,897,321	-\$6,331,070	-\$9,099,586	-\$9,574,826

## **QUEST Expanded Member Months**

The most basic measure of how many members you are impacting through your waiver program is member months. The capitation payment file, which is a detail of all capitation payments made to each plan, is used to calculate these figures. These amounts represents paid member month through June 30, 2012. A detailed copy of the member months may be found in Appendix B.

## **Expenditures for QUEST-ACE Program**

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

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

QUEST-ACE started offering coverage for recipients on April 1, 2007. Financial expenditures for QUEST-ACE beneficiaries are approximately \$28 to \$30 million per year in demonstration years 17 and 18 respectively. More information on QUEST-ACE expenditures may be found in Budget Neutrality calculations in Appendix A.

## Recent Initiatives on Measures

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

### HEDIS Initiatives

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

- Implemented health education programs for asthma and physician/patient education on medication.
- Provided community education and outreach activities.
- In 2012, one 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.
- Implemented health education programs for a variety of diabetes-related issues, including healthy eating and weight loss programs, monitoring of alcohol consumption, smoking cessation programs, and physician/patient education on medication. This includes both written and electronic health education materials.
  - In 2011, one health plan reported more members have participated in their Health Media: Care for Diabetes, which is an online program that is free to their members. The program is customized specifically by assessing a member's daily routine, general health and providing ways to manage their diabetes more effectively. The member receives follow-up emails to track their progress. After completing a questionnaire, the member receives an action plan and tools that are tailored to their preferences, and their willingness and ability to use them. The member can review their plan online, or print a copy to discuss with their physician at the next office visit.
- Implemented reminder systems to inform diabetics of needed preventive services and to contact non-compliant members using letters and/or calls. Several health plans also inform providers of members who were overdue for preventive visits and screenings.

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

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

- Provided education to member and provider to increase awareness of cholesterol management and the importance of medication compliance.
- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.
  - One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.
  - One health plan implemented a “Hospital to Home” care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member’s understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member’s case.

***Childhood Immunization Status (CIS) Initiatives:***

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.
- Established patient reminder and recall systems that include: 1) Postcard reminders, and 2) Telephone to non-responders for missed appointments and/or immunizations.
  - One plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.
- Conducted regular assessments of immunization rates.

- One plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the How Are we Doing Reports and conducts systems and process improvement recommendations for underperforming clinics.
- Implemented provider incentives and/or a comparison of performance to a goal or standard.
  - Several plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.
- Implemented mechanisms to collect and report the data in a supplemental database so that immunizations that are provided without a claim being submitted to the plan can still be tracked and reported.

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

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

***Ambulatory Care (AMB) Initiatives:***

- Implemented education of members on appropriate ER use.

- One health plan provided intervention for high utilizers with active case management by clinicians and case managers. Case managers assigned to these members directed them to appropriate care, ensuring that the patient has an assigned PCP, identified any barriers in care, reason for frequent visits to the ER and provided education on appropriate use of the ER.
- One health plan has Disease Management staff address care gaps during the assessment process and follow-up calls, in addition to supporting and reminding members of the importance of complying with disease management recommendations.

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

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

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

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

***Getting Needed Care & Getting Care Quickly Initiatives:***

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

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

## **Physicians’ Assessment Initiatives**

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

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

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

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

- Improved the knowledge base of their employees through various training modalities.
  - One plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.
  - One plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
  - One plan increased staff coaching and mentoring activities.
  - One plan conducted monthly knowledge quizzes to gauge whether additional training is needed.
- Initiated improvements to the prior authorization process.
  - One plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
  - One plan added an online PA application to streamline the PA process.
  - One plan increased provider training and education related to the online PA process.
  - One plan distributed handouts on the PA process during periodic provider relations visits.
  - One plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
  - One plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
  - One plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

## **Home and Community Based Services (HCBS) Initiatives**

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
  - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to “get into a waiver.”
  - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
  - Choices offered include:
    - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
    - Residential settings such as community care foster family homes or assisted living facilities
    - Institutional setting
  - Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
  - DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation
- Standardized assessment tools for HCBS
  - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
  - The use of these assessment tools have helped to streamline receipt of services

## **Hawaii Medicaid Enrollment Initiatives**

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

## Recommendations

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

### 1. Improve process for gathering information from providers

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

Some recommendations for the future are:

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

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

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

### 3. Increase the Pay for Performance withhold from health plans

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

The results of the first year of the program are listed below.

	<b>AlohaCare</b>	<b>HMSA</b>	<b>Kaiser</b>
Childhood Immunization (HEDIS 2010)	No	No	Yes
Chlamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	\$0.40	\$0.40	\$0.80

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

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

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

#### 5. Implement Health Plan Collaborative with EQRO

Part of the Quality Strategy is to have two health plan collaboratives annually. In the health plan collaborative, MQD and its EQRO will meet with health plans to review performance measures over the past year. During these meetings, the health plans and MQD will strategize on techniques to improve the quality of services provided to Medicaid beneficiaries.

The collaborative consist of MQD staff, EQRO staff, health plan administrators, medical directors, and quality improvement staff. MQD will have its first health plan collaborative in the fall of 2012.

#### 6. Revise and update Quality Strategy

MQD will update its quality strategy to add its P4P initiatives. In addition, MQD will expand on the CAHPS requirements in its P4P. These changes will be made to its Quality Strategy by the end of the calendar year.

## Conclusion

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

## Appendix A

Hawaii 1115 QUEST Waiver								
TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal/Extension			Renewal			
WITHOUT WAIVER	FMAP	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%
					67.35%		62.63%	
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	\$261.16	\$281.11	\$302.59	\$322.62	\$343.98	\$366.75	\$391.03
	TANF Adults	\$458.35	\$493.37	\$531.07	\$564.90	\$600.88	\$639.18	\$679.87
	Aged				\$1,204.63	\$1,281.84	\$1,364.01	\$1,451.44
	Blind/Disabled				\$1,489.42	\$1,597.11	\$1,712.58	\$1,836.40
Member Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	1,282,911	1,261,533	1,193,278	1,540,890	1,994,062	2,130,996	2,166,975
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	\$402,056,806	\$424,960,513	\$443,327,661	\$837,493,616	\$1,343,204,149	\$1,520,758,456	\$1,631,791,072
DSH		\$80,364,047	\$81,971,327	\$83,856,667	\$87,546,360	\$89,735,019	\$91,350,249	\$94,547,507
Total Ceiling		\$482,420,853	\$506,931,840	\$527,184,328	\$925,039,976	\$1,432,939,168	\$1,612,108,705	\$1,726,338,579
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	\$0	\$0	(\$295)	\$121,310,557	\$314,957,371	\$350,728,888	\$330,293,296
	Aged w /o Mcare	\$0	\$0	\$0	\$2,424,989	\$17,555,107	\$24,896,097	\$19,060,304
	B/D w /Mcare	\$0	\$0	(\$13,736)	\$31,795,707	\$74,850,400	\$81,249,425	\$77,690,468
	B/D w /o Mcare	\$0	\$0	(\$28,991)	\$81,514,842	\$211,801,011	\$248,768,345	\$251,740,251
	Breast Cervical Cancer Treatment (BCCT)	\$0	\$0	\$0	\$0	\$4,051	\$545,195	\$734,188
	CURRENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	CURRENT POP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Current-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Demo Elig Adults	\$127,983,510	\$129,458,220	\$154,645,707	\$177,396,443	\$201,629,508	\$238,017,265	\$245,339,887
	FosterCare(19-20)	\$0	\$0	\$91,499	\$83,366	\$94,158	\$137,233	\$77,745
	Haw aiiQuest-1902(R)(2)	\$0	\$0	\$33,061	\$26,332	\$8,001	\$0	\$0
	HCCP	\$0	\$0	\$135,520	\$683,159	\$0	\$0	\$0
	HealthQuest-Current	(\$2,325,152)	\$0	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Others	(\$621,643)	\$0	\$0	\$0	\$0	\$0	\$0
	Med Needy Adults	\$56,504	\$120,767	\$115,693	\$58,345	\$117,005	\$109,837	\$8,305
	Med Needy Children	\$0	\$0	\$0	\$7,715	\$3,960	\$0	\$0
	MFCP	\$0	\$0	\$122,839	\$581,513	\$0	\$0	\$0
	NH w/o W	\$0	\$0	\$5,100,418	\$16,199,737	\$0	\$0	\$0
	Opt St Pl Children	\$76,678	\$103,084	\$80,075	\$257,166	\$253,182	\$31	\$0
	Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Others-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	OthersX	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	QUEST ACE	(\$2,751)	\$798,681	\$5,696,094	\$14,353,208	\$23,872,001	\$30,434,166	\$28,884,029
	RAACP	\$0	\$0	\$7,862,479	\$17,432,949	\$0	\$0	\$0
	St Pl Adults-Preg Immig/COFAs	\$0	\$0	\$0	\$0	\$24,990	\$2,622,138	\$2,718,679
	State Plan Adults	\$111,983,043	\$118,021,622	\$109,034,691	\$128,225,127	\$132,187,409	\$123,786,545	\$118,966,463
	State Plan Children	\$181,803,156	\$179,673,972	\$155,394,295	\$168,854,083	\$203,903,281	\$214,486,295	\$199,141,564
	Supp. - Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Supp. - State Gov.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	UCC-Governmental	\$15,688,221	\$22,546,108	\$18,919,184	\$16,356,580	\$24,507,605	\$34,064,491	\$40,634,690
	UCC-Private	\$10,056,500	\$3,403,710	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$0
		\$444,698,066	\$454,126,164	\$464,688,533	\$785,061,818	\$1,213,269,040	\$1,357,345,951	\$1,315,289,869
		-\$1,459,097	-\$1,189,919	-\$660,309	-\$4,962,002	-\$38,297,536	-\$43,476,661	-\$38,375,159
		\$443,238,969	\$452,936,245	\$464,028,224	\$780,099,816	\$1,174,971,504	\$1,313,869,290	\$1,276,914,710
		\$39,181,885	\$53,995,595	\$63,156,104	\$144,940,160	\$257,967,664	\$298,239,415	\$449,423,868
		\$565,691,724	\$619,687,319	\$682,843,423	\$827,783,582	\$1,085,751,247	\$1,383,990,662	\$1,833,414,530
		-\$334,903	-\$352,488	-\$217,644	-\$22,587	-\$15,945,497	-\$15,835,580	-\$10,164,390
		-\$323,973	-\$263,058	-\$239,466	-\$19,777	-\$6,517,946	-\$9,185,458	-\$9,300,862
		-\$347,005	-\$279,056	-\$147,219	-\$22,317	-\$9,503,023	-\$9,356,037	-\$9,335,080
		-\$453,216	-\$295,317	-\$55,980	-\$4,897,321	-\$6,331,070	-\$9,099,586	-\$9,574,826

## **Appendix B**

<b>Medicaid Eligibility Groups</b>	<b>FPL Level and/or other qualifying Criteria</b>	<b>DY 12</b>	<b>DY13</b>	<b>DY14</b>	<b>DY15</b>	<b>DY16</b>	<b>DY17</b>	<b>DY18</b>
<b>Mandatory State Plan Groups</b>								
Pregnant women and infants under age 1	Up to 185 % FPL	150,628	148,567	153,476	178,999	189,018	166,869	139,838
Pregnant IMM/COFA						1,954	8,929	6,198
Children 1-5	Up to 133% FPL	312,242	314,820	304,250	341,362	381,974	408,973	416,975
Children 6-18	Up to 100% FPL	499,619	491,766	472,432	505,116	583,763	635,484	663,188
Adult/Children AFDC related family members covered by Section 1931	Up to 100% FPL	270,986	255,563	235,530	253,126	287,428	332,051	353,628
Transitional Medicaid (Section 1925) Children	Coverage is for two six-month or one four-month periods due to increased earnings or child support, respectively, make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL	30,924	32,168	18,780	29,595	29,465	33,520	41,623
Section 1925 Transitional Medicaid Adults	Coverage is for two six-month periods due to increased earnings, or for four months due to receipt of child support, either of which would otherwise make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL	18,055	17,604	7,165	16,619	15,317	19,267	24,467
<b>Optional State Plan Groups</b>								
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Up to 100% FPL	456	442	594	496	538	689	407
Children through the S-CHIP Medicaid expansion	101 - 200% FPL and for whom the State is claiming Title XXI funding	187,674	195,679	201,322	215,957	250,263	254,863	269,437
Medically Needy Adults and Children	Up to 300% FPL, if individuals otherwise eligible under State Plan groups described above spend down to Medicaid income limits. (Benefits are FFS)							
CHIPRA					2	7,097	41,552	41,185
Children who are not eligible for SCHIP	201- 300% FPL - who could be eligible through 1902 (r) (2) and for whom the State is claiming Title XIX funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	1	603	1,051	2,100	2,761		
<b>Demonstration Eligible Groups</b>								
Adult AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid.	Up to 100% FPL (using TANF methodology)	1,913	1,541	1,814	613	259	169	170
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Up to 100% FPL (using GA methodology)	38,252	39,232	41,860	48,602	49,051	53,112	54,883
Childless adults who meet Medicaid asset limits.	Up to 100% FPL (subject to an enrollment cap presently set at 125,000)	270,673	256,759	268,786	296,483	355,006	422,282	457,190
Quest Net Adults	Up to 100% FPL Eligible to enroll in QUEST but elected QUEST-Net	4,711	4,383	4,433	3,115	3,179	3,324	3,690
Quest Net Adults	Up to 300% FPL but exceed QUEST asset or income	10,377	10,071	9,997	9,790	9,458	9,372	9,059
QUEST ACE		1,132	22,587	70,038	115,481	135,427	150,098	
<b>QUEST-Net-Children</b>								
<b>Demonstration Eligible Groups</b>								
Children who could be eligible for SCHIP	201-300% FPL for whom the State is claiming Title XXI funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	8,943	10,129	20,253	29,714	35,478	42,539	46,322
<b>Total</b>		1,806,586	1,801,914	1,811,781	2,047,170	2,337,436	2,583,093	2,528,260