Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: December 15, 2017 (via email); April 27, 2018 (via PMDA/CMA)

Demonstration/Quarter Reporting Period

Demonstration Year:	23rd Year	(10/1/2016 - 9/30/2017)
Federal Fiscal Quarter:	FFY 2017 3rd Q.	(4/1/2017 - 6/30/2017)
State Fiscal Quarter:	SFY 2017 4th Q.	(4/1/2017 - 6/30/2017)
Calendar Year:	CY 2017 2nd Q.	(4/1/2017 - 6/30/2017)

Introduction

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

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

The State's goals in the demonstration are to:

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

Enrollment Information

Note: Enrollment counts include both person counts (unduplicated members) and member months. Member months and unduplicated members data for April 2017 through June 2017.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 04/2017 - 06/2017	Unduplicated Members 04/2017 - 06/2017
Mandatory State Plan Groups			
State Plan Children	State Plan Children	368,249	119,223
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	119,935	38,507
Aged	Aged w/Medicare Aged w/o Medicare	80,405	26,792
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	77,825	25,751
Expansion State Adults	Expansion State Adults	293,777	94,772
Newly Eligible Adults	Newly Eligible Adults	67,837	21,889
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,303	
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults		
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group		
Total		1,009,331	326,934

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	210,273
Title XXI funded State Plan	26,511
Title XIX funded Expansion	116,661
Enrollment current as of	06/30/2017

Outreach/Innovative Activities

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

In addition to encouraging applicants to apply through the KOLEA system, DHS-Med-QUEST Division established a new branch in December, 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. HCOB collaborated with Federally Qualified Health Centers (FQHCs) and contracted Navigator organizations to focus its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers and justice-involved populations. Due to the multiple challenges faced by these individuals/families, they are traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that can meet the people where they congregate and offer on-the spot application assistance has been helpful in serving this high-risk population.

For those in the community who are below the 138% of the Federal Poverty Level, but who were deemed ineligible for Medicaid due to their citizenship status (Immigrants here less than 5-years and non-pregnant, non-blind, non-disabled 19-64 year olds from the Nations under the Compact of Free Association, including the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau) the HCOB team provided assistance with the completion of Marketplace applications for health insurance if the individual qualified for a Special Enrollment Period. HCOB also reviewed and determined applicants' eligibility for the State of Hawaii's Premium Assistance Program (PAP). This program provides premium assistance to individuals who were deemed ineligible for Medicaid due to citizenship; whose households are below 100% of the FPL and who enrolled in a Silver level plan on the Marketplace. The PAP program is an innovative approach Hawai'i uses to help those who are living in poverty gain access to the benefits of health insurance by paying for the remaining portion of a PAP qualified individual's premium not covered by the APTC they are eligible for. This expanded assistance is vital to meeting the expectations of the ACA that require individuals without qualified exemptions be insured.

Med-QUEST has a new data share agreement that will help be a source for MQD and the Department of Public Safety (DPS) to ensure we suspend coverage for those that enter incarceration. We are also working closely with select staff from DPS to establish a process which will assist those leaving incarceration with access to health coverage. Additionally, HCOB recently met with the Hawaii State Hospital (HSH) to discuss current processes for suspending Med-QUEST benefits for those who are admitted to HSH, along with processes for assisting those being discharged from HSH with access to health coverage.

Operational/Policy Developments/Issues

During the third quarter of FFY17, the Med-QUEST Division (MQD) continued its monitoring of the QUEST Integration (QI) implementation. QUEST Integration or QI is a melding of both the QUEST and QExA programs. The QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition. In QI, health plans will provide a full-range of comprehensive benefits including long-term services and supports. The MQD has lowered its ratios for service coordination.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ‘Ohana Health Plan, and UnitedHealthcare Community Plan. The MQD has been assuring readiness of the five (5) QI health plans since February of 2014, and has since moved from transition-centric activities to on-going contract monitoring activities.

The MQD held a public forum on 1115 Medicaid Waiver on June 19, 2017. This public forum session from 8:30 a.m. to 11:30 a.m. was held in Kalanimoku State Office Building. This location has access to video teleconference (VTC) for streaming information to Kapolei on Oahu, and to other islands including Kauai, Maui and Hawaii. Information regarding the 1115 Medicaid Waiver was given to the attendees, and attendees were given the opportunity to provide comments and solicit feedback on the new requirements.

Submission of HCBS Settings Rule Statewide Transition Plan

The state received initial approval on January 13, 2017. MQD is working in collaboration with the My Choice My Way advisory group on transition plan updates to achieve final approval. In addition, the state is working on completing the milestones requirement. MQD continues to hold monthly meetings with the advisory group to discuss the implementation of the transition plan. Bi-annual public information sessions are held to provide updates regarding the transition plan and guidance on the HCBS requirements. Information and trainings are provided to the public in person, webinar, or written as stated in the transition plan.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for third quarter of FFY17 was already submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (April 2017)	Month 2 (May 2017)	Month 3 (June 2017)	Total for Quarter Ending 06/2017
EG 1-Children	123,475	122,605	123,472	369,552
EG 2-Adults	39,973	39,793	40,169	119,935
EG 3-Aged	26,518	26,614	27,273	80,405
EG 4-Blind/Disabled	25,941	25,867	26,017	77,825
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	121,043	119,304	121,267	361,614

This member month reporting related to the budget neutrality for third quarter of FFY17 was submitted.

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (April 2017)	Month 2 (May 2017)	Month 3 (June 2017)	Total for Quarter Ending 06/2017
State Plan Children	123,051	122,168	123,030	368,249
State Plan Adults	39,973	39,793	40,169	119,935
Aged	26,518	26,614	27,273	80,405
Blind or Disabled	25,941	25,867	26,017	77,825
Expansion State Adults	98,074	96,896	98,807	293,777
Newly Eligible Adults	22,969	22,408	22,460	67,837
Optional State Plan Children				
Foster Care Children, 19-20 years old	424	437	442	1,303
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children				
VIII-Like Group	0	0	0	0

This member month reporting related to the budget neutrality for third quarter of FFY17 was submitted.

QUEST Integration Consumer Issues

HCSB Grievance
During the third quarter of FFY17, the HCSB continued to handle incoming calls. The clerical staff take the basic contact information and assign each call to one of the social workers. MQD tracks all of the calls and resolutions. If the client call is an enrollment issue (i.e., request to change health plan), then the HCSB staff will refer such telephone call to the Customer Service Branch (CSB) which will work with the client to resolve the issue(s).

During the third quarter of FFY17, the HCSB staff, as well as other MQD staff, processed approximately 24 member calls.

HCSB:	Member Grievance Calls	Provider Grievance Calls
April 2017	11	0
May 2017	5	0
June 2017	8	0
Total	24	0

HCSB Appeals
The HCSB received eight (8) member appeals in the third quarter of FFY17. DHS resolved four (4) of the appeals with the health plans in the member's favor prior to going to hearing.
Of the eight (8) appeals filed, the types of appeals were medical (2), medication (1), LTSS (2), and DME (3).

Appeals	Member #
Submitted	8
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	4
Member withdrew hearing request	0
Resolution in DHS favor	2
Resolution in Member's favor	1
Still awaiting resolution	1

Types of Member Appeals	#
Medical	2
LTSS	2
Other: Medications DME	1 3

Provider Interaction

The MQD and the health plans continue to have two regularly scheduled meetings with providers. One of the meetings is a monthly meeting with the Case Management Agencies. MQD focuses the meetings with these agencies around continually improving and modifying processes within the health plans related to HCBS. In addition, every other month, the MQD, AMHD and health plans meet with the behavioral health providers that directly serve the CCS population. The focus of these meetings is to address ongoing issues and the needs of this fragile population.

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

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

Enrollment of individuals

During the third quarter of FFY17, 322 individuals chose their health plan when they became eligible, 2,371 changed their health plan after being auto-assigned.

In addition, DHS had 123 plan-to-plan changes during the third quarter of FFY17. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 5 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

	#
Individuals who chose a health plan when they became eligible	322
Individuals who changed their health plan after being auto-assigned	2,371
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	123
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	5

Long-Term Services and Supports (LTSS)

HCBS Waiting List

During the third quarter of FFY17, the QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the third quarter of FFY17, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring long-term services and supports continues to increase. The third quarter of FFY17, yielded an increase of 34.9% from the number of beneficiaries receiving long-term services and supports at the start of the program. The number of beneficiaries in nursing facilities decreased this reporting quarter from the previous

reporting quarter. The HCBS usage more than doubled, since the time the program for the aged, blind, and disabled changed to managed care (formerly QUEST Expanded Access (QExA), currently QUEST Integration). Nursing facility services decreased by 17.5% since the program inception.

The third quarter of FFY17, yielded an increased of 105.3% in the number of beneficiaries receiving HCBS since the program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving long-term services and supports. This percentage increased to 64.9% in the third quarter of FFY 17.

	2/1/09	2nd Qtr FFY17, av	3rd Qtr FFY17, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 3rd Qtr FFY17
HCBS	2,110	4,281	4,332	105.3%↑	42.6%	64.9%
NF	2,840	2,364	2,344	17.5%↓	57.4%	35.1%
Total	4,950	6,645	6,676	34.9%↑		

Behavioral Health Programs Administered by the DOH and DHS

Individuals in Community Care Services (CCS) have a Serious Mental Illness (SMI) diagnosis or Serious and Persistent Mental Illness (SPMI) with functional impairment. The Medicaid beneficiaries who continue to receive services from AMHD are legally encumbered. These individuals are under court order to be cared for by AMHD.

Program	#
Adult Mental Health Division (AMHD/DOH)	154
Early Intervention Program (EIP/DOH)	564
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,138
Community Care Services (CCS/DHS)	4,968

The Early Intervention Program (EIP) under the DOH provides behavioral health services to children from ages zero (0) to three (3). EIP is providing services to approximately 564 children during the third quarter FFY17.

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (21). CAMHD is providing services to approximately 1,138 children during the third quarter FFY17.

QUEST Integration Contract Monitoring

The MQD moved all of its QUEST and QExA population into the QUEST Integration (QI) program on January 1, 2015. The transition was seamless with all five-health plans being ready to accept their new members. As the QI program matures, the MQD has begun more traditional and on-going contract monitoring and oversight activities.

The MQD continued to conduct three additional oversight processes. Information about these programs

is included below.

1. **Ride-Along program**
   MQD nurses and socials workers went on home visits with service coordinators to observe their conducting assessments and developing service plans. These Ride-Alongs identified areas for improvement to include pre-filling assessments prior to the visit, talking with member to obtain information instead of reading the questions from the assessment tool, and listening to needs of the member more than paying attention to questions on the assessment tool. MQD shared these observations with health plan leadership in April 2015. This program has been temporarily suspended, and is in the process of being modified and improved for a second wave of future Ride-Alongs.

2. **Customer Service Call Listen-In program**
   MQD staff listed to live health plan QUEST Integration customer service calls to ensure that customer service representatives were meeting MQD contract requirements. Initially, all five health plans had room for improvement. After providing health plans with a summary of the listen-in program, all five health plans are performing at 100%. MQD continues to listen to calls to support our beneficiaries.

3. **Updating of the Health & Functional Assessment (HFA) & Service Plan (SP) Forms**
   MQD staff is in the final stages of updating the HFA and SP forms. We have taken feedback from the service coordinators, health plans, and members during the Ride-Along program mentioned above, and used this feedback to revise and/or rewrite both of these forms. The main goals of these changes were to decrease the time needed to conduct the HFAs by streamlining the HFA, and to make changes so that the HFA and SP are more Person-Centered in the framing and language used. Plans are to complete these changes sometime in the next quarter.

Quality Assurance/Monitoring Activity

MQD Quality Strategy

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

MQD continues to update its quality oversight of home and community based services, which will affect mostly our QI health plans, the DDID program, and the Going Home Plus program. MQD uses quality grid based upon the HCSB Quality Framework for monitoring the DDID program. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also been working on behavioral health monitoring and quality improvement.

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

financial incentives.

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015, and subsequently submitted a revised draft quality strategy on September 30, 2015. MQD received further feedback from CMS on April 5, 2016, and subsequently submitted a revised draft quality strategy on May 6, 2016. In a letter from CMS dated July 8, 2016, Hawaii received final approval of its Quality Strategy from CMS.

Quality Activities During The Quarter (April 2017 to June 2017)
The External Quality Review Organization (EQRO) oversees the health plans for the QI and Community Care Services (CCS) programs. Health Services Advisory Group (HSAG), the EQRO, performed the following activities this quarter:

1. Validation of Performance Improvement Projects (PIPS) –
   - Provided PIP technical assistance to health plans.
   - Provided technical assistance to one health plan on the *new* PIP topics.
   - Sent the Module 1 and Module 2 submission forms for the new PIPs to the health plans.
   - Received and reviewed the Module 4 and Module 5 resubmissions on 04/28/17.
   - Provided final validation feedback tools on Module 4 and Module 5 to the health plans on 05/30/17.
   - Received (on 6/30/17) and is currently reviewing the Module 1 and 2 submissions from the health plans for the new PIPs.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –
   - In April, finalized source code review for four (4) health plans.
   - Conducted on-site visits with all five (5) health plans.
   - Completed convenience sample review for all five (5) health plans.
   - Conducted preliminary rate review with all five (5) health plans.
   - Submitted preliminary post onsite reports and updated IS Grids to all five (5) health plans.
   - Provided ongoing technical assistance for the MQD and health plans.
   - In May, completed source code review of non-HEDIS measures for one health plan.
   - Received responses from four (4) health plans regarding HSAG's preliminary rate review.
   - Completed medical record review validation for four (4) health plans.
   - HSAG granted an extension to one health plan for submitting medical records due to non-compliant.
   - In June, continued follow-up with health plans to address any outstanding IS Grid items.
   - Continued to address IS Grid items with the health plans; closed out all outstanding items and received attestations.
   - Completed rate review for HEDIS and state-specific measures for all health plans.
   - Notified the MQD of HSAG's concern regarding the CAHPS sample frame population omission.
   - Locked and submitted all IDSS to NCQA.
   - Provided technical assistance to the MQD and health plans, as required.

- Completed medical record review validation one health plan.
- Worked with two health plans on correcting rates for the PCR measure.
- Completing final rate review and ensuring rates are submitted to the IDSS for HEDIS measures.
- Provided ongoing technical assistance for the MQD and health plans.

3. Compliance Monitoring –
   - Submitted answers to questions raised by CCS and QI plans regarding the 2017 compliance monitoring reviews on 04/03/17.
   - Received CCS and QI plans' desk review documents on 04/12/17 and 04/21/17. Followed up with CCS and QI plans on outstanding or incomplete submissions.
   - Ongoing review of CCS and QI plans' documents and preparing preliminary findings and interview questions in the compliance review tool.
   - At end of May and throughout June, conducted health plan on-site monitoring reviews.
   - Began drafting compliance monitoring reports.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   - Sent weekly disposition reports to the MQD.
   - Refreshed phone number files prior to CATI using Telematch on 04/07/17.
   - Began CATI for non-respondents on 04/13/17.
   - Performed CATI monitoring of survey vendor on 04/18/17.
   - Completed CATI for non-respondents on 04/28/17.
   - Notified the MQD that the survey field has been closed on 05/01/17.
   - Received final data files from subcontractor on 05/22/17.
   - Sent the MQD the 2017 CAHPS Database Submission Memo and associated documents on 05/30/17.
   - Submitted Medicaid survey data to NCQA for all health plans on 05/31/17.
   - Notified the MQD that NCQA data submission was completed on 05/31/17.
   - The MQD re-activated their CAHPS Database account on 06/12/17.
   - Submitted the CAHPS information, surveys, and data files to the CAHPS Health Plan Database on behalf of the MQD on 06/13/17.

5. Provider Survey –
   N/A for 2017.

6. Annual Technical Report –
   - Submitted *Follow-up Prior EQRO Recommendations* documentation request to health plans on 04/03/17.
   - Began preparing 2017 EQR technical report template.
   - Submitted technical report template to the MQD on 05/05/17.
   - HSAG met with the MQD to review proposed technical report template. MQD approved new format.
   - In May and June, continued preparing for production of 2017 EQR technical report template; working with Subject Matter Experts to collect results and recommendations.

7. Technical Assistance to the MQD
    - Submitted validation results from review of MQD's P4P result spreadsheet on 05/04/17.
    - Received request from the MQD on 05/23/17 to review and respond to CMS MacPro *Seek More Information* (SMI) inquiry; submitted response on 05/26/17.
    - Received request from MQD on 05/31/17 to review additional CMS SMI inquiry regarding MACPRO submission.
    - Submitted response to the CMS SMI inquiry on 6/16/17.
    - Post technical specifications for proposed ED Visits for Ambulatory Care-Sensitive Conditions to the QI plans on 06/03/17.
    - Submitted technical specifications for proposed ED Visits for Ambulatory Care-Sensitive Conditions to the QI plans on 06/03/17.
    - Submitted respond to CMS SMI inquiry MACPRO submission on 06/20/17.
    - Received request from the MQD regarding PCR measure; submitted response to the MQD on 06/26/17.
    - Participated on conference call with the MQD concerning questions from Hawaii hospitals related to P4P measures on 06/28/17; submitted additional information on 06/29/17.

Demonstration Evaluation

MQD submitted its QUEST Integration Draft Evaluation Design to CMS on December 18, 2014. CMS responded with comments on September 9, 2015. The MQD has reviewed the CMS comments and had concerns about a few items. During a Quarterly 1115 Waiver Monitoring Call on October 21, 2015 the MQD shared that there were a few concerns and requested an extension on the existing deadline of November 9, 2015. CMS agreed on an extended deadline, and that a new deadline will be determined after a pending conference call to discuss these concerns. The list of concerns was sent to CMS on November 12, 2015. After a Demonstration Evaluation follow-up call that occurred on April 20, 2016, the MQD submitted on April 22, 2016 the quality measures/quality monitoring/quality projects related to the HCBS/LTSS populations that have occurred recently. The MQD then received feedback from CMS on March 10, 2017 and subsequently submitted a modified Demonstration Evaluation Design back to CMS on June 16, 2017.

Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for April 2017 – June 2017

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