CMS Quarterly Report

FFY 2018 3rd Quarter

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: September 5, 2018

Reporting Period: April 2018 – June 2018

Federal Fiscal Quarter:	3rd Quarter
State Fiscal Quarter:	4th Quarter
Calendar Year:	2nd Quarter
Demonstration Year:	24th Year (10/1/2017 – 9/30/18)

I. Introduction

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria, to beneficiaries eligible under the State Plan and to the Demonstration populations.

During the reporting period, MQD focused on a comprehensive internal quality improvement project, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. Internal training sessions were held in mid-May 2018.

Additionally, MQD continued progress on its 1115 Waiver renewal. In particular, MQD staff reviewed comments submitted by the public regarding the 1115 Demonstration Extension. The notice for the 1115 Demonstration Extension was posted to the public on February 15, 2018, and public comments were due to MQD by March 19, 2018. Also, two public hearings were held. One was held on March 2, 2018 and the other was held on March 6, 2018. A second public comments period will begin during the next reporting quarter.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending June 30, 2018 will be submitted by the August 31, 2018 deadline.

III. Events Affecting Healthcare Delivery

A. Benefits

Supportive Housing Amendment

PPDO staff have been working intensely with the Centers for Medicare and Medicaid Services (CMS) to add this amendment to the current 1115 Demonstration waiver. This amendment will increase access to supportive housing services to individuals who are chronically homeless or in danger of losing public housing with either a physical or behavioral illness. These services include helping to complete a housing application, stewarding resources and income, working with landlords, getting along with neighbors, and other skills to help individuals be able to live in the community on their own.

1115 Demonstration Renewal

The current 1115 Demonstration expires December 31, 2018. The Policy and Program Development Office (PPDO) and MQD administration have been working with CMS on the 1115 renewal. The State will request approval from the federal government to continue to deliver services through managed care under existing waiver authorities, but also seeks to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care. MQD anticipates that investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and a continued sustainable growth rate in Medicaid spending. To this end, MQD has also procured consultants to assist in developing ways to achieve the following goals:

- Improve health outcomes for demonstration populations;
- Maintain a managed care delivery system that achieves appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Support strategies and interventions targeting the social determinants of health.

To test these goals, MQD proposes the following evaluation hypotheses:

- Increasing utilization of primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.
- Improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for high-needs, high-cost individuals.

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- Implementing alternative payment methodologies (APMs) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Managed Care Organization (MCO) level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
- Providing community integration services and similar initiatives for vulnerable and at risk adults and families will result in better health outcomes and lower hospital utilization.

Collaboration with the Department of Education to increase Medicaid Claiming for School Based Services

In an effort to help with this initiative, in April 2018 the Hawaii legislature adopted Senate Concurrent Resolution No. 81, REQUESTING THE ESTABLISHMENT OF A WORKING GROUP TO EXAMINE HOW THE DEPARTMENT OF EDUCATION CAN MAXIMIZE MEDICAID REIMBURSEMENT FOR SUPPORT SERVICES OFFERED TO ELIGIBLE STUDENTS DURING SCHOOL HOURS. This workgroup consists of decision making staff from the Department of Education (DOE) and the Med-QUEST division, as well as Deputy Attorney's General from DOE and DHS, Chair of Senate Committee on Education and Chair of House of Representatives Committee on Education, to serve as co-chairs, and other persons invited by the workgroup as appropriate. The workgroup will be examining maximizing Medicaid reimbursement of support services offered during school hours by the Department of Education including by not limited to, Occupational and physical therapy, speech pathology, applied behavior analysis, and other wellness supports that benefit a student's learning and growth. The group shall report its findings and any other actions taken pursuant to this measure no later than twenty days prior to the convening of the Regular Session of 2019.

B. Enrollment and Disenrollment

The MQD Customer Service Branch (CSB) assumes responsibility for assisting applicants with completing a Medicaid application by phone. Upon completion, CSB offers to pre-enroll individuals that select a QUEST Integration (QI) health plan at the time of application. This activity improves the enrollment choice process and reduces cycle time to client enrolling in preferred health plan.

The QI health plan agreement allows individuals the opportunity to select a health plan during the initial enrollment period and allowable change period of 90 days. Another opportunity is during annual plan change. Health plans may agree to allow individuals to change health plans outside of the allowable choice period. Such change requires an agreement between the loosing and gaining health plan. Change is effective the first day of the next month. QI health plans agreed upon enrollment change for 133 individuals.

A single QI health plan, serving two islands, imposed an enrollment limit statewide. Certain exceptions apply, (1) Newborn enrollment match the mother's QI enrollment or into a QI plan offered by the same insurer as mother's commercial plan, (2) Clients that have a Primary Care Physician (PCP) or behavioral health providers exclusive to a plan within 12 months, (3) Client regains eligibility within six months, and (4) children under foster care, kinship guardianship, or subsidized adoption. Notwithstanding the aforementioned, this QI health plan allowed enrollment for 45 individuals.

Outreach

The Health Care Outreach Branch (HCOB), working collaboratively with Federally Qualified Community Health Centers (FQHC's) and contracted Navigator organizations (Kōkua Services) continues to improve and refine its approach to conducting on-going outreach, education and health coverage in-person enrollment assistance in the community statewide, targeting hard to reach populations and 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, justice-involved populations and those who are admitted to and discharged from public institutions.

HCOB and our three (3) contracted organizations under the Kōkua Services Contracts, completed enrollment efforts for the contracted fiscal year ending on 6/30/18. Med-QUEST Division (MQD) also extended these contracts for an additional year, to begin on 7/1/18 to assist continued efforts of enrollment as well as prepare for the upcoming 2019 open enrollment period on the Federal Health Insurance Marketplace which begins on November 1, 2018.

Additionally, HCOB continues to work with clients and issuers to review and determine applicants' eligibility for the State of Hawaii's Premium Assistance Program (PAP), the State's innovative approach to helping those who are living in poverty, are deemed ineligible for Medicaid due to their citizenship status, whose households are below 100% of the Federal Poverty Level (FPL) 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 Advanced Premium Tax Credit (APTC) they are eligible for, thus meeting the expectations of the Affordable Care Act (ACA) which require individuals without qualified exemptions be insured.

C. Complaints/Grievances

There are 26 complaints/grievances in this reporting period. See Section IX A for monthly count.

D. Quality of Care

One of the activities that MQD has worked on in the past quarter is telehealth services. While telehealth has been available for behavioral health services, the passage of a State statute made coverage for telehealth mandatory for any services that would be covered if the service were provided through in-person consultation.

The MQD is reviewing implementation of the statute by the managed care plans (e.g. utilization of telehealth, procedures being utilized, provider/specialties utilizing the service, etc.). Initial MQD memorandums QI-1702 and QI-1702A issued on January 13th and May 2nd of 2017, provided general telehealth guidance, and suggested procedure codes that are readily delivered via the telehealth modality. As MQD is able to better analyze the data, MQD may need to issue guidance regarding coverage that ensures quality of care being delivered/received.

E. Access that is Relevant to the Demonstration

An event affecting access to healthcare delivery, which occurred on May 3, 2018, was the volcanic eruption of Kilauea on the island of Hawaii. Some services were affected due to road closures and mandatory evacuations. The MQD coordinated with health plans to ensure that service authorizations were relaxed, medication access

and delivery continued uninterrupted, and vulnerable and impacted Medicaid members were relocated. For more details, see Section XIII below.

F. Pertinent Legislative or Litigation Activity

There was no pertinent litigation activity during this period.

A chart of pertinent laws passed by Governor Ige after the 2018 Legislative Session follows:

ACT	Bill Reference	Bill Topic	Summary	Special Notes
2	HB2739 HD1	Health; Our Care, Our Choice Act	Establishes a regulated process under which an adult resident of the State with a medically confirmed terminal disease and less than six months to live may choose to obtain a prescription for medication to end the patient's life. Imposes criminal sanctions for tampering with a patient's request for a prescription or coercing a patient to request a prescription.	For Medicaid recipients, federal funds will not be available to cover the prescription costs, only state funds will be used.
13	SB270 SD1 HD2 CD1	Sexual Orientation Change Efforts; Conversion Therapy; Prohibition; Minors; Licensed Professionals; Sexual Orientation Counseling Task Force	Prohibits specific state-licensed persons who are licensed to provide professional counseling from engaging in, attempting to engage in, or advertising sexual orientation change efforts on minors. Establishes the sexual orientation counseling task force to address the concerns of minors seeking counseling on sexual orientation, gender identity, gender expressions, and related behaviors.	
55	HB694 HD2 SD1 CD1	DHS; Med-QUEST Division; State Health Planning and Development Agency; Health and Healthcare Information and Data; Health Analytics Program; Appropriation	Establishes the Health Analytics Program in the Med-QUEST Division of the Department of Human Services and authorizes the Department of Human Services to maintain an all-payers medical claims database. Appropriates funds for the establishment of two full-time equivalent positions.	Med-QUEST has hired a lead for this new Branch.

78	HB2144 HD1 SD1 CD1	Medicaid; Inmate; Public Institution; Prisons; Jails; Correctional Facilities	Requires the Department of Public Safety to inform inmates of the availability of assistance to secure or verify applicable Medicaid eligibility prior to an inmate's release.	
111	SB2340 SD2 HD1 CD1	Health Insurance; Extended Coverage; Preexisting Conditions; Nondiscrimination	Ensures certain benefits under the federal Affordable Care Act are preserved under Hawaii law, including: extending dependent coverage for adult children up to 26 years of age; prohibiting health insurance entities from imposing a preexisting condition exclusion; and prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.	Impact to program will happen if ACA provisions are invalidated Federally.
116	HB2729 HD2 SD2 CD1	Medical Cannabis; Reciprocity; Written Certification; Testing; Telehealth; Manufactured Cannabis Products; Dispensaries; Employees; Working Group	Establishes standards and criteria for reciprocity for qualifying out-of-state medical cannabis patients and caregivers including limitations, and safeguards. Authorizes extension of written certifications of a debilitating condition for up to three years for chronic conditions. Clarifies a dispensary licensee's right to retest marijuana or manufactured cannabis products for compliance with standards. Authorizes establishment of a bona fide provider-patient relationship via telehealth. Authorizes dispensing of devices that provide safe pulmonary administration of medical cannabis by dispensary licensees. Increases the allowable tetrahydrocannabinol limit for of certain manufactured cannabis products. Limits felony convictions that disqualify an individual from employment with a dispensary licensee. Establishes a working group to make recommendations regarding employment of qualifying patients and manufacture and dispensing of edible cannabis products.	Section 24 provides for physician-patient relationship may be established via telehealth, provided that certifying a patient for medical use of cannabis via telehealth only after initial in-person consultation

125	HB1812 HD3 SD2	Health Care Surrogate; Medicaid Authorized Representative Application	Authorizes a health care surrogate to act as a Medicaid authorized representative to assist a patient with a Medicaid application and eligibility process and in communications with the Department of Human Services. Specifies the duties and obligations of the surrogate.	
136	SB2487 HD1 CD1	Health; Quality Assurance Committees; Definition	Amends the definition of "quality assurance committee" to include committees established by long-term care facilities, skilled nursing facilities, assisted living facilities, home care agencies, hospices, and authorized state agencies. Allows for the creation of a quality assurance committee outside of a single health plan or hospital.	
139	SB2799 SD1 HD2 CD1	Licensed Dental Hygienists; Public Health Setting; Supervision	Clarifies the scope of practice of licensed dental hygienists in a public health setting.	
144	SB122 SD2 HD2 CD1	Mental Health; Notice; Hearings	Provides designated family members and other interested persons with notice when an individual with a mental health emergency is subject to certain procedures and actions. Provides designated family members and other interested persons with the right to be present for the individual's hearings and receive a copy of the hearing transcript or recording unless the court determines otherwise. Requires a court to adjourn or continue a hearing for failure to timely notify a person entitled to be notified or for failure by the individual to contact an attorney, with certain exceptions. (CD1)	

146	HB1916 HD2 SD2 CD1	Alzheimer's Disease and Related Dementias; State Plan Updates; Executive Office on Aging	Requires the Executive Office on Aging to biennially update the state plan on Alzheimer's disease and related dementias, include an implementation work plan for each goal in the state plan, and include information on progress made toward the goals of the state plan on Alzheimer's disease and related dementias in its annual report to the legislature.	
147	HB1906 HD2 SD2 CD1	Health Care Worker; Intentionally or Knowingly Causing Bodily Injury; Felony Assault in the Second Degree	Makes intentionally or knowingly causing bodily injury to certain health care workers a Class C felony.	
148	HB1911 HD2 SD1 CD1	Care Facilities; Uncertified; Unlicensed; Enforcement; Community-based Care Home; Adult Care Center; Criminal Penalty	Authorizes the Department of Health to investigate care facilities reported to be operating without an appropriate certificate or license issued by the Department. Establishes penalties for violations and for knowingly referring or transferring patients to uncertified or unlicensed care facilities, with certain exceptions. Excludes landlords from licensure, under certain conditions.	
152	HB2384 HD1 SD1	Uniform Controlled Substances Act; Withdrawal; Detoxification; Maintenance	Updates Uniform Controlled Substances Act for consistency with federal law. Allows prescription of drugs to patients undergoing medically managed withdrawal, also known as detoxification treatment and maintenance treatment, by practitioners who are properly registered.	
153	SB2646 SD1 HD3 CD1	Electronic Prescription Accountability System; Prescription Drugs	Requires prescribers of certain controlled substances to consult the State's Electronic Prescription Accountability System before issuing a prescription for the controlled substance, under certain circumstances. Provides that a violation by a prescriber shall not be subject to criminal penalty provisions but that a violation may be grounds for professional discipline. Repeals on 6/30/2023.	

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154	SB2247 SD1 HD2 CD1	Opioid Antagonists; Prescriptions; Dispensing; Pharmacists	Authorizes pharmacists to prescribe, dispense, and provide related education on opioid antagonists to individuals at risk of opioid overdose and to family members and caregivers of individuals at risk of opioid overdose without the need for a written, approved collaborative agreement; subject to certain conditions.	
155	SB2244 SD1 HD2 CD1	Workers' Compensation; Opioid Therapy; Informed Consent; Prescription Limits	Requires health care providers in the workers' compensation system who are authorized to prescribe opioids to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency. Establishes limits for concurrent opioid and benzodiazepine prescriptions.	
161	SB2488 SD2 HD1 CD1	Medical Cannabis; Health Insurance Reimbursement; Working Group	Establishes the Medical Cannabis Insurance Reimbursement Working Group to address the complexities surrounding the topic of making medical cannabis reimbursable by health insurance.	MQD Director named to the working group; long term may require State funds for reimbursement
185	SB2647 HD3	Mental Health Counselors; Licensure; Qualifications; Practicum Experience	Amends the practicum experience requirements for qualification for licensure as a mental health counselor.	
192	HB1520 HD2 SD1 CD1	Short-term, Limited-duration Health Insurance; Insurers; Renewal or Reenrollment; Prohibition	Prohibits an insurer from renewing or re-enrolling an individual in a short-term, limited-duration health insurance policy or contract if the individual was eligible to purchase health insurance through the federal health insurance marketplace during an open enrollment period or special enrollment period in the previous calendar year. Specifies that short-term, limited-duration health insurance shall be subject to the same provisions of the insurance code currently applicable to limited benefit health insurance.	

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197	HB2145 HD1 SD1 CD1	Health Insurance; Medication Synchronization; Prescription Drug Coverage; Patients; Network Pharmacies	Allows the synchronization of plan participants' medications. Requires plans, policies, contracts, or agreements that are offered by health insurers, mutual benefit societies, and health maintenance organizations and provide prescription drug benefits, to apply prorated daily cost-sharing rates for prescriptions dispensed by network pharmacies for less than a thirty-day supply.	
198	HB2149 HD1 SD1	Dentistry; Dentists; Continuing Education; Ethics; Board of Dental Examiners	Amends the ethics training requirement for dentists in the continuing education program to be six hours of ethics training within the previous two years for each biennial renewal period.	
199	HB2208 HD1 SD1 CD1	Association Health Plan Policies; Authorization	Requires association health plan policies to comply with the laws of this State regardless of the association's domicile. Enables certain voluntary associations, including employer associations that issue association health plans, to qualify for authorization to transact insurance in the State.	
205	HB2271 HD2 SD1 CD1	Practice of Behavior Analysis; School Setting; Applied Behavior Analysis; Developmental Disabilities; Department of Education; Applied Behavior Analysis; Implementation Plan; Reporting; Scope of Practice; Medicaid	Updates and standardizes the terminology used to refer to behavior analysts and applied behavior analysis. Clarifies the licensing exemptions for certain individuals who provide behavior analysis services. Requires the Department of Education to create and implement a plan to provide Medicaid billable applied behavior analysis services to all students diagnosed with autism spectrum disorder within the Department. Establishes reporting requirements.	
209	SB2401 SD2 HD1 CD1	Homelessness; Housing; Ohana Zones Pilot Program; Emergency Department Homelessness Assessment Pilot Program; Medical Respite Pilot Program;	Establishes the Ohana Zones Pilot Program, the Emergency Department Homelessness Assessment Pilot Program, and the Medical Respite Pilot Program. Makes appropriations.	

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		Law Enforcement Assisted Diversion; Appropriations		

IV. Adverse Incidents

(Including abuse, neglect, exploitation, mortality reviews and critical incidents that result in death, as known or reported)

Med-QUEST Division is not aware of any adverse incidents occurring during this reporting period.

V. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data

Med-QUEST Division continues a monthly encounter validation meeting with all participating MCOs to address major issues. In particular, MQD is working with the MCOs to correct MCO existing encounter editing errors, which the State system denies. Med-QUEST Division also works with its contractor, Milliman, to use the currently submitted encounters to generate financial reports, and compare financial reports submitted by MCOs to validate completeness of encounters. The goal is to use the State Medicaid encounter system to generate robust financial reports, and use them to monitor the MCOs, and set up the Per Member Per Month (PMPM) capitation payment plans for MCOs.

At the current time, the financial reports generated from the State encounter system and those from the MCOs, differ from less than 5% to over 25% (based on the form types). Med-QUEST Division is working with MCOs to decrease these differences.

VI. Initiatives and Corrective Action Plans

for Issues Identified In:

A. Policy

During the reporting period, no policy issues were identified for any initiatives or corrective action plans.

B. Administration

During the reporting period, no administrative issues were identified for any initiatives or corrective action plans.

C. Budget

There were no significant issues this quarter.

VII. Monthly Enrollment Reports for Demonstration Participants

(Include the member months and end of quarter,
point-in-time enrollment for each demonstration population)

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**04/2018 - 06/2018**	**04/2018 - 06/2018**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	358,960	116,834
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	116,468	36,591
Aged	Aged w/Medicare Aged w/o Medicare	113,266	27,249
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	71,945	24,541
Expansion State Adults	Expansion State Adults	287,319	95,585

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Newly Eligible Adults	Newly Eligible Adults	67,604	22,021
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,289	
Total*		1,016,851	322,821

*CHIP Program enrollment is not included.

State Reported Enrollment in the Demonstration	**Current Enrollees**
Title XIX funded State Plan	205,215
Title XXI funded State Plan	27,371
Title XIX funded Expansion	117,606
Enrollment current as of	6/30/2018

Enrollment in Behavioral Health Programs

Point-in-Time (1st day of last month in reporting quarter)

Program	**# of Individuals**
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,735**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**753**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,106**
Adult Mental Health Division (AMHD/DOH) Uninsured, underinsured, and/or encumbered adults with SMI who meet the program criteria, receive integrated mental health services that are	**142**

culturally responsive and based on a best practices system to support recovery, by the state Department of Health.	

VIII. Number of Participants who Chose an MCO and Number of Participants who Change Plans After Auto-Assignment

Enrollment of Individuals

	#
Individuals who chose a health plan when they became eligible	**302**
Individuals who changed their health plan after being auto-assigned	**2098**
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	**133**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**6**

During the third quarter of FFY 2018, 302 individuals chose their health plan when they became eligible, 2098 changed their health plan after being auto-assigned. Also, 8,514 individuals had an initial enrollment which fell within the third quarter of FFY 2018.

In addition, 6 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

IX. Member Complaints, Grievances, and Appeals, Filed during the Quarter, by Type

(Types shall include access to urgent, routine, and specialty care)

A. Complaints/Grievances

During the FFY 2018 3rd quarter, MQD received and addressed the following number of members complaints.

Month	# of Member Complaints/Grievances
April 2018	7
May 2018	11
June 2018	7
Total	**26**

B. Appeals

The Health Care Services Branch (HCSB) processed nine (9) member appeals (see table below) in the third quarter of FFY18. All of these appeals were appealing the health plan's decision to reduce or deny services. Five (5) of the appeals were withdrawn or dismissed because MQD did not agree with the health plan's denial or reduction or the member had not gone through the health plan appeal process first. In these situations, through MQD's intervention, the beneficiaries received the services that they had submitted the appeal for initially.

There are two (2) appeals pending as the hearing has not occurred yet, or the hearing officer has not yet issued a decision.

Of the nine appeals filed, the types of appeals were medical (2), Long Term Services and Supports (LTSS) (4), Van Modification (1), Applied Behavior Analysis (ABA) (1), and Durable Medical Equipment (DME) (1).

Member Appeals	#
Submitted	9
Department of Human Services (DHS) resolved with health plan or Department of Health – Developmental Disabilities Division (DOH-DDD) in member's favor prior to going to hearing	5
Dismiss as untimely filing	1
Member withdrew hearing request	0
Resolution in DHS favor	1
Resolution in Member's favor	0
Still awaiting resolution	2

Types of Member Appeals	#
Medical	2
LTSS	4
Van modification	1
ABA	1
DME	1

X. Evaluation Activities and Interim Findings

A. Evaluation Activities

(A summary of the progress of evaluation activities, including key milestones accomplished, plus challenges encountered and how they were addressed.)

Final Rules

During the reporting period, MQD worked with CMS on the QI RFP Supplemental Changes #9 regarding 2018 rates and scope.

The MQD also worked with CMS for approval of the 2013 Community Care Services (CCS) Request for Proposal (RFP) rates and scope. Final approval from CMS was received on July 10, 2018. During the next reporting period, MQD continues to work with CMS on requirements for the new 2018 CCS RFP.

New Procurement – IDIQ RFP

The MQD completed procurement for its new Indefinite Delivery/Indefinite Quantity (IDIQ) RFP and awarded 11 contractors for future task orders. These task orders will assist MQD in meeting goals on various projects, including the 1115 Waiver, new QI RFP, primary care services, and focus on high-needs/high-costs issues.

B. Interim Findings

During the reporting period, no interim findings were identified for any initiatives or corrective action plans.

XI. Quality Assurance and Monitoring Activity

Quality Activities during the Quarter April to June 2018

The External Quality Review Organization (EQRO) oversees the health plans for the Quest Integration (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)

   April:

   - Provided PIP Module 4, one of the phases of PIP, technical assistance (TA) to some health plans.

   May:

   - Continued to provide PIP Module 4 technical assistance to a health plan.
   - Sent a request to the health plans on 05/09/18 to submit a Module 4 progress update for both PIPs by 05/23/18.
   - Received Module 4 progress updates from some health plans.
   - Followed-up with a health plan to submit a Module 4 progress update by 06/08/18.
   - Provided Module 4 feedback.

   June:

   - Received the remaining Module 4 progress updates.
   - Provided remaining Module 4 feedback.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

   April:

   - Conducted on-site visits with health plans.
   - Completed remaining source code review for the HEDIS measures.
   - Provided additional guidance to the health plans for reporting the Emergency Department Use without Hospitalization (EDUH) measure and an extension for source code submission until 04/27/18.
   - Received preliminary rates from health plans for non-HEDIS measures and began preliminary rate review.
   - Conducted medical record review validation (MRRV) process training with health plans in April 2018.
   - Completed convenience sample over-reads some health plans.

May:

- Forwarded initial audit findings reports to the health plans and the MQD.
- Ongoing source code review for the non-HEDIS measures.
- Provided preliminary rate feedback to health plans for HEDIS measures by 05/04/18.
- Received Attachment 2: Final medical record (MR) Summary Counts from health plans by the 05/09/18 11:59pm PDT deadline.
- Provided MRRV Measure Selection Letters to health plans by the 05/10/18 12:00pm (noon) PDT deadline.
- Received Attachment 3: MR Numerator Positive Case Listings and Attachment 4: MR Exclusions Case Listings from health plans by 05/11/18.
- Provided MRRV Case Selections to health plans by 05/11/18.
- Received all medical record documentation from health plans by 05/15/18.
- Provided MRRV results, including corrective actions, to health plans by 05/31/18.
- Received all corrective actions (if applicable) and MRRV follow-up requests from health plans by 05/31/18.
- Received preliminary rates for State custom measures via HSAG Excel reporting template by 05/11/18.
- Alerted the plans that reporting of the EDUH and ED Visits for Ambulatory Care-Sensitive Conditions (NYU) measure would not be included in the HEDIS® 2018 timeline.
- Received health plan submissions of final rates [Interactive Data Submission System (IDSS) and non-HEDIS measure Excel template] and confirmed plan locks were applied to IDSS submissions by 06/01/18. The earlier National Committee for Quality Assurance (NCQA) deadline for HEDIS 2018 was met and health plans submitted a PLD file for each IDSS submission.
- Conducted final rate review and ensured Patient-Level-Detail (PLD) files matched the corresponding IDSS data by 06/15/18.
- Provided feedback to health plans; QI health plans submitted responses to the auditor's questions and made corrections as needed by 06/15/18.
- Approved final rates (IDSS submissions and HSAG rate reporting templates.) Monitored that health plans submitted the auditor-locked IDSS submissions, with attestations, to NCQA on 06/15/18.

  Provided additional guidance to the health plans for reporting the *EDUH* measure and the *NYU* measure.

June:

- Received health plan submissions of final rates (IDSS and non-HEDIS measure Excel template) and confirmed plan locks were applied to IDSS submissions by 06/01/18. The earlier NCQA deadline for HEDIS 2018 was met and health plans submitted a PLD file for each IDSS submission.
- Conducted final rate review and ensured PLD files matched the corresponding IDSS data by 06/15/18.
- Provided feedback to health plans; QI health plans submitted responses to the auditor's questions and made corrections as needed by 06/15/18.
- Approved final rates (IDSS submissions and HSAG rate reporting templates). Monitored that health plans submitted the auditor-locked IDSS submissions, with attestations, to NCQA on 06/15/18.
- Provided additional guidance to the health plans for reporting the *EDUH* measure and the *NYU* measure.

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3. Compliance Monitoring

April:

- Received feedback from the MQD on proposed corrective action plan (CAP) updates on 04/19/18.
- Submitted CAP feedback and request for documentation to the health plans on 04/26/18.

May:

- Received documentation of completed CAP activities from the health plans on 05/18/18 and 05/22/18.
- Began review of documentation.
- Review of CAPs for all health plans, except for one health plan; preparing CAP documentation for health plans.

June:

- Completed review of CAPs for all health plans, except for one; continued to prepare CAP documentation for health plans.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

April:

- Submitted weekly disposition reports of survey responses to the MQD.
- Mailed second questionnaires and second cover letters to non-respondents on 04/02/18.
- Mailed second postcard reminders to non-respondents on 04/09/18.
- Began Computer Assisted Telephone Interviewing (CATI) for non-respondents on 04/23/18.

May:

- Submitted weekly disposition reports of survey responses throughout the survey administration to the MQD.
- Completed CATI for non-respondents on 05/07/18.
- Received data files from subcontractor on 05/18/18.
- Informed the MQD that the NCQA data files were submitted by the 05/30/18 deadline.
- Submitted the final, reconciled disposition report to the MQD on 06/01/18.
- Informed the MQD that the data was accepted in the CAHPS Database on 06/21/18.

June:

- Submitted the final, reconciled disposition report to the MQD on 06/01/18.
- Informed the MQD that the data was accepted in the CAHPS Database on 06/21/18.

5. Provider Survey

April:

- Attended Provider Survey kick-off call on 04/06/18.
- Submitted timeline and sampling plan to the MQD on 04/18/18.
- Submitted the 2018 administrative forms and associated documents, and sample frame file instructions to the MQD on 04/30/18.
- Began discussions with the MQD regarding the upcoming Provider Survey administration on 04/06/18.

June:

- Met and discussed the status of the HI Provider Survey project with the MQD on 06/22/18.
- Received feedback on the survey instruments and text for cover letters and email reminders, as well as completed administrative forms from the MQD on 06/22/18.
- Submitted an updated timeline to the MQD on 06/28/18.

6. Annual Technical Report

- Completed 2017 draft technical report; submitted to MQD on 04/19/18.
- Received the MQD's feedback on the 2017 draft technical report on 04/26/18.
- Posted final 2017 draft technical report to the MQD on 04/27/18.
- Prepared final printed copies of 2017 EQR Technical Report.
- Began preparing 2018 technical report outline for review with MQD.

7. Technical Assistance

April:

- Continued technical assistance calls and email updates with the health plans regarding EDUH measure.
- Received request from the MQD to discuss sampling recommendations for conducting audit of CCS care management oversight on 04/10/18. Met with the MQD on 04/18/18.
- Received request from the MQD to assist in presenting CMS State Health Plan Performance scorecard data; submitted preliminary and final charts on 04/27/18.

May/June:

- Continued technical assistance calls and email updates with the health plans regarding EDUH measure.
- Received request to calculate remaining funds in Technical Assistance funding; submitted response to the MQD and confirmed dollars could be used to support Provider Survey enhancements.
- Continued technical assistance calls and email updates with the health plans regarding EDUH measure.

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XII. Quality Strategy

Impacting the Demonstration

(A report on the implementation and effectiveness
of the updated comprehensive Quality Strategy as it impacts the demonstration)

QI MCO Pay for Performance (P4P) Payments

On April 9, 2018 the MQD delivered P4P checks to the QI MCOs based on the results from the Calendar Year (CY) 2016 period. As happened in the CY 2015 period there were P4P checks delivered to all five QI MCOs, and the total P4P amount delivered by the MQD for CY 2016 of $3.6 million was slightly higher than the $3.4 million delivered for CY 2015.

Electronic Visit Verification (EVV)

Another requirement of the 21st Century Cures Act is the implementation of Electronic Visit Verification. During the previous reporting period, 7 informational sessions on EVV were held. A provider survey was also circulated during the previous period. During this reporting period, MQD continues to communicate with health plans and providers on implementation requirements. Also, MQD and Arizona Health Care Cost Containment System (AHCCCS) are partnering to procure a single EVV vendor to implement and operate one statewide EVV system for Hawaii and for Arizona. Using the data and comments collected during the informational sessions and provider survey, joint work by AHCCCS and MQD has begun on a draft EVV RFP.

One Shared Future

Med-QUEST Division leaders attended a comprehensive training program for leaders called, “One Shared Future”. It began in March 2018 and continued through June 2018.

KALO Project

Med-QUEST Division launched a project named KALO, which stands for Kokua Aloha Lokahi Ohana. The KALO project emphasizes leadership skills and business process redesign. It represents MQD’s journey to improve customer service and build a positive work environment.

XIII. Other

Kilauea Volcano Impacts and Health Plan Actions

Aloha Care, HMSA, Ohana, and United Healthcare

Kilauea volcano on the island of Hawaii erupted on Thursday May 3, 2018. Health plans Aloha Care, Hawaii Medical Service Association (HMSA), Ohana, and United Healthcare reported impacts on providers and members to MQD. Kaiser does not service members on the island of Hawaii.

In general, reported impacts on providers were mixed. Two health plans reported that no providers were impacted. The other two reported receiving little feedback or no return calls from providers. However, one provider in the affected area did communicate with its health plan that an increase in respiratory and eye conditions occurred, and that general provider concerns included effects on access to services, supplies, transportation, mail service and clean air. Also, one health plan reported having several providers in or near evacuation zones and stated that those providers likely employ staff who reside in affected areas.

Reported impacts on members included high stress levels and worry about finding appropriate alternative housing and shelter, maintaining health amid poor air quality and other hazards, and the condition or destruction of personal property and belongings. Members experienced mandatory evacuations, water catchment issues, blocked roads, denied access to Highway 130, and health issues due to vog and ash.

Health plan reported actions include coordinated and increased outreach to members in affected areas, and expanded staff to focus on the new demand. Additionally, health plans assisted members with emergency preparedness and provided information on shelters and other appropriate relocation alternatives, Civil Defense updates, and transportation and prescription accommodations. In order for members to maintain access to medications some health plans made appropriate adjustments regarding early refills or refill edits for routine prescription medications and network pharmacy limitations. Some health plans also relaxed transportation policies, and coordinated with transportation and medical service providers, to ensure doctor appointments and periodic services such as dialysis, were maintained. To assist the community in general, health plans also provided donations, including N95 masks, to various non-profits and shelters, and reported staff volunteer work in various relief efforts.

CCS Ohana

In the days leading up to the eruption, frequent seismic activity prompted OHANA Community Care Services (CCS) service coordinators to begin reaching out to members to discuss emergency preparations. There was a total of 117 CCS members residing in the affected area. No providers have been affected.

OHANA CCS service coordinators proactively offered services such as crisis support and counseling. The transportation provider IntelliRide, reached out to check on the status of members with upcoming appointments and was also instructed to approve requests even if there wasn't sufficient notice.

After the eruption on May 3, 2018 OHANA CCS updated their website and social media platforms in an attempt to disperse as much information as possible. Members were notified that prescription drugs could be refilled early at any pharmacy and IntelliRide would be available to assist in evacuations if needed. Contact information of the Hawaii County Civil Defense and American Red Cross Shelters were added.

On an on-going basis OHANA CCS continues to communicate and assist members with their needs. Service coordinators outreach regularly to ensure there are no gaps in services. N95 masks are available to all members at OHANA Health Plan's (OHP) Hilo office and as of today OHP has donated over 20,000 masks to the entire Hawaii county community.

MQD Action regarding Kauai Flooding and Kilauea Volcano

The Policy and Program Development Office, MQD administration, and the KOLEA team worked with CMS to extend Eligibility Review (ER) dates for beneficiaries affected by the Kauai flooding and areas affected by the volcano on the island of Hawaii to ensure continuation of services.

MQD Workshops and Other Events

Training Focus: Participant Rights For: Adult Foster Home Association (AFHA) Oahu Chapter			
Trainer	Aileen Manuel	**Location**	Seafood City Waipahu, Hawaii
Length	1.0 hour	**Dates**	April 19, 2018
Attendees	92		
Description	This module provides individuals with operational guidance on participant rights and provider responsibilities.		
Objectives/Outcomes	• Overview of Medicaid HCBS final rule • Intent of the final rule • HCBS settings requirements- Participant Rights (privacy and visitors) • Resources		

Training Focus: Participant Rights For: Adult Foster Home Association (AFHA) Oahu Chapter			
Trainer	Aileen Manuel	**Location**	Seafood City Waipahu, Hawaii
Length	1.0 hour	**Dates**	June 21, 2018
Attendees	78		
Description	This module provides individuals with operational guidance on participant rights and provider responsibilities		
Objectives/Outcomes	• Overview of Medicaid HCBS final rule • Intent of the final rule		

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	• HCBS settings requirements- Participant Rights (privacy and visitors) • Resources

Focus: Non-Medication Strategies For: QI Health Plan Service Coordinators/Case Managers			
Trainer	Aida Wen, M.D.	**Location**	Webinar
Length	1.0 hour	**Dates**	April 17, 2018
Attendees	approximately 200		
Description	Non-pharmacological interventions for dementia behavior management and describe counseling options and resources for families.		
Objectives/Outcomes	• Understand the impact of dementia behaviors on caregivers and the healthcare system. • Be able to assess dementia behaviors • Know what non-pharmacological interventions for dementia behavior management are effective. • Be able to provide initial counselling and resources to support caregivers for loved ones with dementia behaviors		

Focus: Advance Care Planning For: QI Health Plan Service Coordinators/Case Managers			
Trainer	Jeannette Koijane, MPH	**Location**	Webinar
Length	1.0 hour	**Dates**	May 15, 2018
Attendees	161		
Description	Learn about the importance of conversations about Advance Care Planning to prevent crisis and honor patients' wishes. Advance directive forms, Physicians Order for Life Sustaining Treatment (POLST), and the "Conversation Starter Kit for Loved Ones of People with Dementia"		
Objectives/Outcomes	• Define and understand the importance of advance care planning. • Understand the difference between advance directives and physician orders for life sustaining treatment • Learn about the Conversation Toolkit and tips for families to have conversations about end of life wishes		

Focus: Dementia or Delirium For: QI Health Plan Service Coordinators/Case Managers			
Trainer	Aida Wen, M.D.	**Location**	Webinar
Length	1.0 hour	**Dates**	June 19, 2018
Attendees	130		
Description	Difference between delirium and dementia		

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Objectives/Outcomes	• Causes of altered mental status • Difference between Dementia and Delirium • Medical causes of delirium • Medications used to treat dementia and delirium • Non-pharmacologic behavior management

A. Enclosures/Attachments

Attachment: QUEST Integration Dashboard for April 2018 – June 2018

B. MQD Contact(s)

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