Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: April 27, 2018

Demonstration/Quarter Reporting Period

Demonstration Year:	23rd Year	(10/1/2016 - 9/30/2017)
Federal Fiscal Quarter:	FFY 2017 4th Q.	(7/1/2017 - 9/30/2017)
State Fiscal Quarter:	SFY 2018 1st Q.	(7/1/2017 - 9/30/2017)
Calendar Year:	CY 2017 3rd Q.	(7/1/2017 - 9/30/2017)

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 July 2017 through September 2017.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 07/2017 - 09/2017	Unduplicated Members 07/2017 - 09/2017
Mandatory State Plan Groups			
State Plan Children	State Plan Children	366,568	118,579
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	119,099	38,065
Aged	Aged w/Medicare Aged w/o Medicare	81,909	27,216
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	77,858	25,764
Expansion State Adults	Expansion State Adults	295,022	95,057
Newly Eligible Adults	Newly Eligible Adults	68,425	21,988
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,293	
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		1,010,174	326,669

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	209,624
Title XXI funded State Plan	26,654
Title XIX funded Expansion	117,045
Enrollment current as of	09/30/2017

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 data share agreement in place between MQD and the Department of Public Safety (DPS) to ensure we suspend coverage for those that enter incarceration. Additionally, we work collaboratively to ensure applications are submitted to Medicaid for those leaving incarceration and if determined eligible they have coverage upon being released from the institution. Currently we are focusing on the max-out population and those being released into programs, assisted by Honolulu County Offender Reentry Program (HCORP).

HCOB has established a partnership with the Hawaii State Hospital (HSH) working collaboratively to ensure those being admitted to HSH who have active Medicaid coverage, have their case suspended until which time they are released from HSH. HSH will alert MQD of members release date and MQD will re-activate Medicaid coverage if the member is still eligible.

Operational/Policy Developments/Issues

During the fourth quarter of FFY17, MQD continued its monitoring of the QUEST Integration implementation. QUEST Integration (QI) is a melding of both the QUEST and QUEST Expanded Access (QExA) programs. The QI program utilizes a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QExA programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with the 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, ʻOhana 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.

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 fourth quarter of FFY17 was already submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (July 2017)	Month 2 (August 2017)	Month 3 (September 2017)	Total for Quarter Ending 09/2017
EG 1-Children	123,355	122,400	122,106	367,861
EG 2-Adults	40,044	39,518	39,537	119,099
EG 3-Aged	27,284	27,281	27,344	81,909
EG 4-Blind/Disabled	25,989	25,866	26,003	77,858
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	121,731	120,288	121,428	363,447

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

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (July 2017)	Month 2 (August 2017)	Month 3 (September 2017)	Total for Quarter Ending 09/2017
State Plan Children	122,923	121,979	121,666	366,568
State Plan Adults	40,044	39,518	39,537	119,099
Aged	27,284	27,281	27,344	81,909
Blind or Disabled	25,989	25,866	26,003	77,858
Expansion State Adults	98,770	97,605	98,647	295,022
Newly Eligible Adults	22,961	22,683	22,781	68,425
Optional State Plan Children				
Foster Care Children, 19-20 years old	432	421	440	1,293
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 fourth quarter of FFY17 was submitted.

QUEST Integration Consumer Issues

HCSB Grievance

During the fourth 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 fourth quarter of FFY17, the HCSB staff, as well as other MQD staff, processed approximately 30 member calls.

HCSB:	Member Grievance Calls	Provider Grievance Calls
July 2017	9	0
August 2017	10	0
September 2017	11	0
Total	30	0

HCSB Appeals

The HCSB received seven (7) member appeals in the fourth quarter of FFY17. DHS resolved six (6) of the appeals with the health plans in the member's favor prior to going to hearing.

Appeals	Member #
Submitted	7
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	6
Member withdrew hearing request	0
Resolution in DHS favor	1
Resolution in Member's favor	0
Still awaiting resolution	0

Of the seven (7) appeals filed, the types of appeals were: three (3) medical; and four (4) LTSS.

Types of Member Appeals	#
Medical	3
LTSS	4
Other: Medications	0
DME	0

Provider Interaction

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

In addition, every quarter, 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.

MQD was notified in the early summer of 2017 that the 21st Century Cures Act deadline of January 1, 2018 to contract with 100% of Medicaid providers applies to not only the FFS providers but the MCO providers as well. Up to this point MQD was under the assumption that we only needed to contract with the FFS providers. Several communications were sent out to MCO providers in the summer of 2017, and this resulted in an enormous increase in the volume of providers calls and emails to MQD. We are currently working and meeting with Health Plans and providers to continue the effort to contract with 100% of the Medicaid providers in Hawaii.

Enrollment of Individuals

During the fourth quarter of FFY17, 500 individuals chose their health plan when they became eligible, 2,426 changed their health plan after being auto-assigned. Also, 10,144 individuals had an initial enrollment which fell within the fourth quarter of FFY17.

In addition, DHS had 149 plan-to-plan changes during the fourth 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, 12 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	500
Individuals who changed their health plan after being auto-assigned	2,426
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	149
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	12

Long-Term Services and Supports (LTSS)

HCBS Waiting List

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

HCBS Expansion and Provider Capacity

During the fourth 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 has decreased slightly from the previous quarter. However, the fourth quarter of FFY17, yielded an increase of 33.3% 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 23.8% since the program inception.

The fourth quarter of FFY17, yielded an increased of 110.1% 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 is at 67.2% in the fourth quarter of FFY17.

	2/1/09	3rd Qtr FFY17, av	4th Qtr FFY17, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 4th Qtr FFY17
HCBS	2,110	4,332	4,433	110.1%↑	42.6%	67.2%
NF	2,840	2,344	2,165	23.8%↓	57.4%	32.8%
Total	4,950	6,676	6,598	33.3%↑		

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)	158
Early Intervention Program (EIP/DOH)	454
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,073
Community Care Services (CCS/DHS)	4,977

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 454 children during the fourth 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 1,073 children during the fourth 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 and the health plans collaborated on the final 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. Changes were completed and the health plans have begun using the new forms.

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 (July 2017 to September 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) –
   - Reviewed the Module 1 and 2 submissions from the health plans.
   - Provided the Module 1 and 2 feedback tools to the health plans and the MQD on 07/28/17.
   - Provided PIP technical assistance to the health plans in preparation for the Module 1 and Module 2 resubmissions.
   - Submitted draft 2017 PIP Validation reports to the MQD for review on 08/29/17.
   - KFHP requested and received MQD approval to extend submission deadline for Module 1 and 2 resubmissions on 08/29/17
   - Provided the health plans with the Version 3 Module 3 submission form on 09/06/17.
   - Received approval of the draft PIP reports from the MQD on 09/14/17.
   - Provided the final PIP reports to the MQD and the health plans on 09/26/17.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –
   - Completed all HP Final Audit Reports and provided them to the MQD, NCQA, and each individual HP.
   - Prepared all HP's final auditor-approved performance rate review tools for analytic team, including NCQA export files and the MQD developed rate review tools.
   - Received updated source code and revised rates for FUM and FUA measures from one health plan; began final rate review. Received primary source documentation from that health plan needed to verify samples of members randomly selected from the FUM and FUA measure lists of numerator compliance cases.
   - Completed primary source verification and conducted final rate review and approved FUM and FUA measures of one health plan.

- Worked with health plans to schedule dates for CY 2018 on-site audits.

3. Compliance Monitoring –
   - Submitted 2017 compliance monitoring reports to the MQD on 07/14/17.
   - Received feedback from the MQD on the 2017 Compliance Monitoring reports on 08/10/17.
   - Submitted an initial response to address the MQD's feedback to the 2017 Compliance Monitoring reports on 08/16/17.
   - Submitted final response to address the MQD's feedback to the 2017 Compliance Monitoring reports on 08/31/17.
   - Received approval from the MQD to submit the draft 2017 Compliance Monitoring reports to the health plans on 09/01/17.
   - Received feedback on the draft 2017 Compliance Monitoring reports from the health plans by 09/11/17.
   - Posted final 2017 Compliance Monitoring reports to all health plans, except KFHP due to feedback requiring research.
   - Conducted research into KFHP's comments and additional documentation to reconcile original findings; response to be submitted to the MQD in October.
   - Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   - Submitted Star Reports to the MQD on 07/10/17.
   - Submitted the raw survey data for each plan and CHIP to the MQD on 07/10/17.
   - Receive feedback on draft reports from the MQD, including confirmation on the number of printed copies of each report the MQD will require by 09/08/17.
   - Submit final reports to the MQD by 09/18/17.
   - Received feedback on draft reports from the MQD, including confirmation on the number of printed copies of each report the MQD required on 09/08/17.
   - Submitted final reports to the MQD on 09/18/17.
   - Shipped final reports to the MQD on 09/27/17.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   Activities have been completed for 2017.

5. Provider Survey –
   N/A for 2017.

6. Annual Technical Report –
   - Continued preparing for production of 2017 EQR technical report template; working with Subject Matter Experts to collect results and recommendations.
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7. Technical Assistance to the MQD –
   - Provided technical assistance to the MQD on the possible use of the PCR measure for hospital-level reporting and excluding BH inpatient stays (07/07/17 and 07/11/17).

- Provided technical assistance to MQD regarding one health plan's use of the code H0031 to capture Mental Health Assessments for the BHA measure for HEDIS 2018 on 07/27/17.
- Provided additional information and documentation related to the NYU Avoidable Visits measure on 07/28/17.
- Provided recommendations to the MQD to address questions from the QI plan related to the Medicaid Managed Final Rule and QI contract on 08/02/17.
- Provided recommendations to the MQD regarding Grievance and Appeals processes on 08/16/17.
- Submitted Encounter Data Validation (EDV) cost proposal to the MQD on 07/28/17.

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. As of the end of the fourth quarter of FFY17, there were no updates to report.

Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for July 2017 – September 2017

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