Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: May 30, 2018

Demonstration/Quarter Reporting Period

Demonstration Year:	24th Year	(10/1/2017 - 9/30/2018)
Federal Fiscal Quarter:	FFY 2018 1st Q.	(10/1/2017 - 12/31/2017)
State Fiscal Quarter:	SFY 2018 2nd Q.	(10/1/2017 - 12/31/2017)
Calendar Year:	CY 2017 4th Q.	(10/1/2017 - 12/31/2017)

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 October 2017 through December 2017.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 10/2017 - 12/2017	Unduplicated Members 10/2017 - 12/2017
Mandatory State Plan Groups			
State Plan Children	State Plan Children	362,497	117,394
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	117,211	37,547
Aged	Aged w/Medicare Aged w/o Medicare	80,725	27,258
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	76,460	25,427
Expansion State Adults	Expansion State Adults	294,039	94,990
Newly Eligible Adults	Newly Eligible Adults	68,455	22,041
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,252	
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		1,000,639	324,657

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	207,626
Title XXI funded State Plan	27,121
Title XIX funded Expansion	117,031
Enrollment current as of	12/31/2017

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 first quarter of FFY18, 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 first quarter of FFY18 was already submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (October 2017)	Month 2 (November 2017)	Month 3 (December 2017)	Total for Quarter Ending 12/2017
EG 1-Children	120,838	121,357	121,554	363,749
EG 2-Adults	39,100	38,956	39,155	117,211
EG 3-Aged	26,373	27,140	27,212	80,725
EG 4-Blind/Disabled	25,549	25,572	25,339	76,460
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	119,225	119,930	123,339	362,494

This member month reporting related to the budget neutrality for first quarter of FFY18 was submitted.

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (October 2017)	Month 2 (November 2017)	Month 3 (December 2017)	Total for Quarter Ending 12/2017
State Plan Children	120,418	120,946	121,133	362,497
State Plan Adults	39,100	38,956	39,155	117,211
Aged	26,373	27,140	27,212	80,725
Blind or Disabled	25,549	25,572	25,339	76,460
Expansion State Adults	96,972	97,382	99,685	294,039
Newly Eligible Adults	22,253	22,548	23,654	68,455
Optional State Plan Children				
Foster Care Children, 19-20 years old	420	411	421	1,252
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 first quarter of FFY18 was submitted.

QUEST Integration Consumer Issues

HCSB Grievance

During the first quarter of FFY18, 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 first quarter of FFY18, the HCSB staff, as well as other MQD staff, processed approximately 30 member calls.

Phone Calls Recvd. by HCSB:	**Member Grievance Calls**	**Provider Grievance Calls**
October 2017	14	0
November 2017	8	0
December 2017	10	0
Total	32	0

HCSB Appeals

The HCSB received ten (10) member appeals in the first quarter of FFY18. DHS resolved seven (7) of the appeals with the health plans in the member's favor prior to going to hearing.
Of the ten (10) appeals filed, the types of appeals were: four (4) medical; four (4) LTSS; and two (2) other.

Types of Member Appeals	**#**
Medical	4
LTSS	4
Other: DME	1
Reimbursement	1

Appeals	**Member #**
Submitted	10
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	7
Member withdrew hearing request	0
Resolution in DHS favor	3
Resolution in Member's favor	0
Still awaiting resolution	0

Provider Interaction

Med-QUEST Division and the health plans continue to have two regularly scheduled meetings with providers. One is a monthly meeting with Case Management Agencies. The focus of these meetings is to continually improve and modify health plan processes concerning the delivery of Home and Community Based Services.

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. Med-QUEST Division will arrange any requested meetings with health plans and provider groups as indicated.

The volume of calls and emails to MQD from providers has enormously increased due to the Federal Requirements of provider enrollment and deadlines. Med-QUEST Division is currently working with health plans with meetings and workshops with the providers.

Enrollment of Individuals

During the first quarter of FFY18, 344 individuals chose their health plan when they became eligible, 2,935 changed their health plan after being auto-assigned. Also, 11,055 individuals had an initial enrollment which fell within the first quarter of FFY18.

In addition, DHS had 110 plan-to-plan changes during the first quarter of FFY18. 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	344
Individuals who changed their health plan after being auto-assigned	2,935
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	110
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 first quarter of FFY18, the QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the first quarter of FFY18, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring LTSS has

decreased slightly from the previous quarter. However, the first quarter of FFY18, yielded an increase of 29.9% 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. Nursing facility services decreased by 27.9% since the program inception.

The first quarter of FFY18, yielded an increase of 107.8% 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 68.2% in the first quarter of FFY18. Finally, the number of beneficiaries receiving HCBS has slightly decreased since the previous reporting period.

	2/1/09	4th Qtr FFY17, mo av	1st Qtr FFY18, mo av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 1st Qtr FFY18
HCBS	2,110	4,433	4,384	107.8%↑	42.6%	68.2%
NF	2,840	2,165	2,048	27.9%↓	57.4%	31.8%
Total	4,950	6,598	6,432	29.9%↑		

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)	159
Early Intervention Program (EIP/DOH)	478
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,089
Community Care Services (CCS/DHS)	4,890

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 478 children during the first quarter FFY18.

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 1,089 children during the first quarter FFY18.

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. **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.

2. **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 (October 2017 to December 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 technical assistance training on the rapid-cycle PIP process to new staff at one health plan.
- Reviewed Module 1 and 2 resubmissions and requested additional resubmissions.
- Provided Module 1 and 2 PIP technical assistance to three health plans.
- Received additional Module 1 and 2 resubmissions.
- Scheduled technical assistance with one health plan to discuss the health plan's questions regarding Module 3.
- In November 2017, finished reviewing and passed the remaining Module 1 and 2 resubmissions.
- Provided Module 3 technical assistance to two health plans.
- Received the Module 3 submissions.
- In December 2017, started reviewing the Module 3 submissions and provided feedback.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –

- Submitted the HEDIS 2018 Record of Administration, Data Management, and Process (Roadmap) to health plans on 10/10/17 following release from NCQA.
- In November 2017, the EQRO received list of performance measures for HEDIS 2018 validation from the MQD.
- The EQRO provided feedback to the MQD on the list of performance measures selected for HEDIS 2018.
- Submitted draft HEDIS 2018 health plan documentation request packets to the MQD for review/approval.
- Received feedback/approval from MQD on HEDIS 2018 health plan documentation request packets.
- In December 2017, received response from the MQD on the final list of performance measures for HEDIS 2018.
- Forwarded HEDIS 2018 document request packets to health plans.

3. Compliance Monitoring –

- Submitted response to one health plan's feedback to 2017 Compliance Monitoring reports.
- Received Corrective Action Plans (CAPs) from all health plans by 10/20/17 (except for one health plan; due 11/10/17); began review and evaluation of proposed health plan CAPs.
- Submitted final Compliance Monitoring report to that remaining health plan.
- In November 2017, received Corrective Action Plans (CAPs) from that health plan on 11/17/17 following MQD extension.
- Began review and evaluation of proposed health plan CAPs.
- Continued review and evaluation of proposed health plan CAPs in December 2017.

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

- EQRO shipped remaining final reports to the MQD on 10/04/17.
- Attended NCQA HEDIS/CAHPS 2018 survey vendor training on 10/11/17.
- In November 2017, prepared survey notification materials for the MQD on 11/06/17.
- Received confirmation from the MQD of the alternate languages to be included for the 2018 Hawaii CAHPS Survey administration on 11/20/17.
- Sent survey notification letter with data submission and administrative requirements to the MQD, including a request for supplemental questions, on 11/22/17.
- Submitted text for cover letters and postcards to the MQD on 11/22/17.
- In December, Received confirmation from the MQD that the same supplemental questions used in 2017 will be included in the 2018 administration on 12/05/17.
- Received final approval from the MQD on cover letters and postcard text, and completed administrative forms on 12/06/17.

5. Provider Survey – Planning to start discussion in spring, for upcoming 2018 survey.

6. Annual Technical Report –

- Continued preparing for production of 2017 EQR technical report template; working with Subject Matter Experts to collect results and recommendations.

7. Technical Assistance –

- Submitted notification to the MQD of an update to the NYU ED utilization algorithm.
- Provided feedback on behavioral health performance measures calculated in other states.
- Provided feedback on Provider Screening/Enrollment memos to health plans.
- Provided information on the availability of technical specifications for Mathematica's *Successful Transitions* measures.
- Received request to develop technical specifications for a *Successful Transition from Long-stay Institution to Community Setting (Successful Transitions)* measure. Submitted follow-up questions to the MQD on 10/30/17.

- In November and December, continued research and preparation of draft technical specifications for new *Successful Transitions* measure.

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 first quarter of FFY18, there were no updates to report.

Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for October 2017 – December 2017

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