CMS Quarterly Report

FFY 2019 2nd Quarter

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: May 31, 2019

Reporting Period: January 2019 – March 2019

Federal Fiscal Quarter:	2nd Quarter 2019
State Fiscal Quarter:	3rd Quarter 2019
Calendar Year:	1st Quarter for 2019
Demonstration Year:	26th Year (1/1/19 – 12/31/19)

I. Introduction

(Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This is likely to be the same for each report.))

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 continued to focus on a comprehensive health care delivery system transformation, 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. Ongoing weekly meetings have been established for the "HOPE Leadership Team" to ensure HOPE initiatives are weaved into the new QI Request for Proposal (RFP). Recent weekly meetings have focused on refining the care coordination/service coordination model for the new QI RFP.

During the reporting period, MQD continued to work with 5 contractors selected for the following task orders: 1115 Waiver; QI RFP; High-Needs/High-Costs; Primary Care; and Project Support. The IDIQ vendor, Healthcare

Management Administrators (HMA), came on-site to meet in person to further refine the RFP language around the new care coordination/service coordination model.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending December 31, 2018 was submitted by the February 28, 2019 deadline. The Budget Neutrality spreadsheet for the quarter ending March 31, 2019 will be submitted to CMS by the May 31, 2019 deadline.

III. Events Affecting Healthcare Delivery

(Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the quarter, including but not limited to the following.)

A. Approval & Contracting with New Plans

No new contract was executed during this reporting period.

B. Benefits & Benefit Changes

1115 Demonstration Renewal

MQD submitted the 1115 Demonstration extension on September 17, 2018 and it was deemed complete by CMS on October 2, 2018. The thirty day comment period for the waiver lasted from October 3, 2018 to November 1, 2018. In November, the State completed CMS' standard funding questions and one round of questions. On December 6, 2018, CMS issued a 6-month temporary extension until June 30, 2019 to allow for more negotiation time between the CMS and MQD. MQD has notified CMS that its major priorities beyond a simple extension of the current program include keeping the 1115 as the vehicle for the creation of home and community-based services, and expanding the CIS benefit to include more services.

CMS and MQD continue to meet regularly on the renewal.

HOPE initiative

PPDO and other MQD staff continue to work with our consultants, stakeholders and other parties to develop implementation plans for the initiatives outlined in our HOPE document. The main focus has been on drafting language for coordination of care issues, which includes detailed MCO Care Coordination, Service Coordination and Treatment Planning, as well as details and language for implementation of Health Homes, which will known as "Hale Ola" , for the MCO RFP that will be released later this year. The coordination language has been challenging as it involves other coordination with other coordination programs such as CCS and CAMHD. This has

required intensive discussions with the HOPE leadership team and the consultants assigned to this task. The other issue we have been focusing on has been Health Prevention and Promotion, which includes services for Diabetes as well as "aspirational services" which could be included, such as pre-diabetes counseling and education, asthma education, cardiac rehab, other disease management classes and counseling, project ECHO and other prevention and health promotion services provided by community health workers.

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

Med-QUEST continues to partner with DOE and assist their staff with Medicaid billing issues. The DOE has increased efforts to comply with federal requirements to ensure Medicaid reimbursement for covered services can be fully utilized. DOE staff have been completing mass mail outs and telephone calls to inform and receive permission from parents to work with Medicaid for medically necessary services during school hours. This effort is taking time, but DOE MQD staff continues to offer guidance and information as needed. The goal is to begin billing for nursing services by June 1, 2019 and to continue working with DOE providers to become Medicaid eligible providers.

Hawaii Administrative Rules

PPDO continues to work on amending the Hawaii Administrative Rules to be in compliance with new federal regulations and guidelines, in addition to housekeeping as needed.

Policy and Program Directives

Part of PPDO's responsibilities include drafting and issuing of Policy and Program Directives (PPDs) to MQD staff for information, clarification and action on affected individuals. PPDs are drafted during the year as requests for clarification of current rules are submitted, or to inform staff of upcoming changes in policy or programs until the Hawaii Administrative rules are amended. PPDO also remains committed to ensuring programs and policies align with State initiatives such as "Ohana 'Nui" and continues collaborative efforts with

Other Duties

In addition to the above, PPDO is tasked with updating/creation of MQD forms, and is in the process of creating Income Eligibility Verification System (IEVS) monitoring, assist staff with clarifications for Administrative appeals, manage the Medicaid Buy-in Program for payment of Medicare premiums for eligible beneficiaries, work closely with our eligibility branch to improve processes and procedures for implementation of programs and policy, participation in various collaborative initiatives with other DHS offices such as BESSD, EOEL, other divisions such as DOE, DOH as well as with both non and for profit agencies to maximize Medicaid impact and benefits for the people of Hawaii.

C. Enrollment and Disenrollment

Med-QUEST Division experienced another slight increase in Medicaid applications completed by phone. During the period, 906 phone applications were processed and clients pre-enrolled in the QUEST Integration health plan of their choice.

The top five languages serviced this reporting period using interpreter assistance included Chinese (Mandarin and Cantonese) (27%), Japanese (12%), Filipino (Ilocano, Tagalog, and Visayan) (14%), Korean (20%), and Spanish (11%).

D. Outreach/Innovative Activities

(Summarize outreach activities and/or promising practices for the quarter.)

The Health Care Outreach Branch (HCOB) Coordinators and Kōkua Service contractors scheduled and participated in over 145 outreach and enrollment events statewide where we provided information about Med-QUEST coverage and services along with information on the Federal Health Insurance Marketplace.

We have scheduled regular monthly times to be at 2 separate transitional shelters to assist those clients who need to apply for health coverage or are having issues with their coverage and we can assist with triaging their issues and in many cases resolving the problems and re-connecting them with health coverage. Also ensuring that we connected them with other services if needed.

We have been working on re-procuring our Kōkua Services contracts for the next fiscal years 2019-2020 and 2020-2021. We issued our RFI on February 15, 2019, issued and posted our RFP on March 29, 2019 and are striving to awarding contracts by May 31, 2019 and a contract effective date of July 1, 2019. The purpose of this contract is to solicit contractor(s) to provide Kōkua Services that includes performing outreach, education and assistance with application submission and health plan enrollment, for uninsured or undersinsured Hawaii residents who may be eligible for health insurance coverage options available through the Medicaid program or the federal health insurance marketplace. Kōkua services will also include referring applicants to other services, specifically around areas related to known social determinants of health.

E. Complaints/Grievances

(QUEST Integration Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Corrective actions and the number of outstanding issues that remain unresolved must be included. Also, discuss feedback received from consumer groups.)

Twenty-four (24) complaints/grievances were received during this reporting period. See Section IX(A) for monthly count.

January 2019 – March 2019 Complaints/Grievances	
Number and Type of Complaints:	**Description :**
3 – Doctor/ Provider	Provider is very unprofessional, unethical behavior and member feels violated. Provider decreasing member's prescription. Doctor does not follow up with members concerns and or respond when requesting referrals. Provider refuses to prescribe a different type of opioids after member said he received an allergic reaction after taking the original prescription from his doctor. Complaint against members' doctor and his office changing his scheduled appointments without informing the member which affected his EBT benefits by him missing an appointment. Lack of quality services from providers office staff. Doctor trying to persuade member they have an option of lethal injections. Complaints about doctors calling members names or saying inappropriate things to the members.

1 - Transportation	Health plan denying flights and airfare for cancer treatments on Oahu, although her doctor pre-approved the treatments and provided referrals and requests.
5 – Health Plan (HP)	Several complaints regarding health plans incorrectly in taking members complaints. Member feels grievances are a pattern and they do not address or solve the complaints accordingly. Many resolutions did not pertain correct information or has been addressed inaccurately. Health plans denying services even though it's medically necessary. Complaints about health plans siding with contractors. Health plan being uncooperative and denying recommended services. Health plans not assisting members with needed services and denying request due to members not submitting enough documentation, but member said they been trying to work with health plans and they are not cooperating. Health plans are not helping or directing members who really need extra services such as coordinators, chores services, flight arrangements and transportation. Workers are not extending their services to members and are not keeping up with obligations for example sending member a copy of their file. HP not allowing member to go into treatment based on her criteria. Complaint against a certain HP who does not accept new providers to be a part of their HP. Health plan sent member to New York and left him there with no return flight, they would approve then quickly unapproved his referral numerous of times. HP is not providing member the benefits which they should be receiving according to their handbook.
2 – Services / Service coordinators & Case managers	Case manager did not assist member with applying for section 8 housing, he had to find help from other means. Member's case manager is not doing anything to help the member. Member who is not mobile has been without a caregiver for weeks and they member can't do anything on their own; members' case service coordinator has been no help.
13 – Miscellaneous	Calling wrong business line. Calls regarding appeals and its process. We explained to the members our Appeals process and provide them with any needed information such as contacts and instructions on how to file. Refer clients to file a grievance with the health plan first before they can file a State Grievance with us. Calls regarding members medical being terminated. Member calls regarding change of health plans. Request for provider applications and questions regarding provider information. Calls to make changes to their Medicaid benefits. Request of certain documents. Provider revalidation questions and concerns; checking on status of applications. Trying to enroll in Medicaid and need assistance. Members need help with denied benefits and or termination of benefits. Complaint against an individual MQD (Med-QUEST division) employee who has been hanging up on the member. Member having problems with MQD customer services. Members calling to follow up on their existing grievances. Member having problems with a MQD worker who intakes his application.

All issues above have been addressed by various MQD staff who have knowledge in the specific subject areas.

F. Quality of Care

Med-QUEST Division continues to work on telehealth services and guidance. Specifically, MQD has had to review coverage of telehealth services under state statutes in order to provide guidance to managed care plans that are also in alignment with our State Plan. Med-QUEST Division has issued guidance to the managed care plans.

Also, MQD continues to work with the managed care health plans on the new reporting requirements for inclusion in the Drug Utilization Review annual report due to CMS. MQD has met with health plan representatives and expects to be able to report on health plan information in the upcoming annual report.

Med-QUEST Division is actively researching the coverage of palliative care in the community setting. It is felt that provision of palliative care, that includes curative care and care management will improve the quality of care and quality of life for recipients. The Division has looked at other States and possible models of care that could be provided under the 1115 waiver in the future.

Med-QUEST Division allows plan-to-plan change after Annual Plan Change with exemption guidelines listed in the MCO RFP. The Division makes sure that the needed services are available from the first day of new plan enrollment.

G. Access that is Relevant to the Demonstration

Kaiser had 3 clinics certified as RHC in Lahaina, Kihei and Kahului.

H. Pertinent Legislative or Litigation Activity

Hawai'i's 2019 Legislative session began on January 16, 2019 and will end on May 2, 2019. A report on and laws or resolutions relevant to our program will be communicated in our Q3 report.

IV. Adverse Incidents

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

A. Medicaid Certified Nursing Facilities

Total of 16 reported adverse incident reports submitted during the period of January – March 2019.

- 10 unattended/unwitnessed fall
- 4 witnessed fall
- 2 unknown cause of pain/skin discoloration

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 11 reported adverse incident reports submitted during the period of January – March 2019.

- 8 ER visits due to illness
- 1 ER visits due to physical Injury (Hernia)
- 2 ER visit-attended fall

B. Long Term Services and Supports (LTSS)

Types of Adverse Events	#			
	Jan 2019	Feb 2019	Mar 2019	**TOTAL**
Fall	53	48	39	140
Hospital	23	25	26	74
Death	7	18	13	38
Emergency Room Visit	10	19	14	43
Injury	9	15	9	33
TOTAL	102	125	101	328

MQD is currently re-structuring the Adverse Events reporting process.

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

(Including information on, and assessment of, the operation of the managed care program in regard to encounter data reporting by each MCO, PIHP, or PAHP.)

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. 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 use them for the annual rate setting process.

At the current time, the financial reports generated from the State Medicaid 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. During the current quarter, after completing the comparison of the MCOs check register totals to submitted encounters, for all pharmacy point-of-sale services, MQD expanded to the comparison of MCO's check registry to the encounters MCOs submitted to the State, in all medical service categories, including inpatient hospital, long term care, other hospital based services, pharmacy utilization and outpatient office visits. This comparison process will continue for the following quarters.

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 & Expenditure Containment Initiatives

(Financial/Budget Neutrality Development/Issues: Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the quarter. Identify the State's actions to address these issues.)

(Expenditure Containment Initiatives: Identify all current activities, by program and/or Demonstration population. Include items such as status, and impact to date, as well as, short and long term challenges, successes and goals.)

There were no significant financial or expenditure issues this quarter.

VII. Monthly Enrollment Reports for Demonstration Participants

(Including member months, as required to evaluate compliance with the budget neutral agreement. Enrollees include all individuals enrolled in the Demonstration.)

A. Enrollment Counts

(Enrollment Information; Enrollment Counts: Enrollment counts must be person counts, not member months. Include the member months and end of quarter, point-in-time enrollment for each demonstration population. The table should outline all enrollment activity under the Demonstration. The State must indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State must indicate that by "0".)

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**1/2019 - 3/2019**	**1/2019 - 3/2019**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	348,657	113,940
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	106,570	34,666
Aged	Aged w/Medicare Aged w/o Medicare	82,116	26,901
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	72,147	24,103
Expansion State Adults	Expansion State Adults	281,159	90,720
Newly Eligible Adults	Newly Eligible Adults	63,694	20,605
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,467	0
Medically Needy Adults	Medically Needy Adults	0	0
Demonstration Eligible Adults	Demonstration Eligible Adults	0	0
Demonstration Eligible Children	Demonstration Eligible Children	0	0
VIII-Like Group	VIII-Like Group	0	0
UCC-Governmental	UCC-Governmental	0	0
UCC-Governmental LTC	UCC-Governmental LTC	0	0
UCC-Private	UCC-Private	0	0
CHIP	CHIP (HI01), CHIPRA (HI02)	88,320	28,108
Total		1,044,130	339,043

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	199,610
Title XXI funded State Plan	28,108
Title XIX funded Expansion	111,325
Enrollment current as of	3/31/2019

B. Member Month Reporting

(Enter the member months for each of the EGs for the quarter.)

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 3/31/19
EG 1 – Children	118,170	117,934	116,951	353,055
EG 2 – Adults	35,614	35,734	35,222	106,570
EG 3 – Aged	27,285	27,369	27,462	82,116
EG 4 – Blind/Disabled	24,055	24,154	23,938	72,147
EG 5 – VIII-Like Adults	0	0	0	0
EG 6 – VIII Group Combined	116,057	114,746	114,050	344,853

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 3/31/19
State Plan Children	116,009	116,626	116,022	348,657
State Plan Adults	35,614	35,734	35,222	106,570
Aged	27,285	27,369	27,462	82,116
Blind or Disabled	24,055	24,154	23,938	72,147
Expansion State Adults	94,399	93,673	93,087	281,159
Newly Eligible Adults	21,658	21,073	20,963	63,694
Optional State Plan Children	0	0	0	0
Foster Care Children, 19-20 years old	479	486	502	1,467
Medically Needy Adults	0	0	0	0
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children	0	0	0	0
VIII-Like Group	0	0	0	0
UCC-Governmental	0	0	0	0
UCC-Governmental LTC	0	0	0	0
UCC-Private	0	0	0	0

C. 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.	**4,493**
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).	**870**
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.	**1,005**
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 culturally responsive and based on a best practices system to support recovery, by the state Department of Health.	**145**

Behavioral Health Programs Administered by the Department of Health (DOH)

(A summary of the programmatic activity for the quarter for demonstration eligibles. This shall include a count of the point in time demonstration eligible individuals receiving MQD FFS services through the DOH CAMHD and AMHD programs.)

See table above in Section B, for the count of demonstration eligibles who access DOH services.

AMHD discontinued Representative Payee services. Effective May 1, 2019, this service has been transferred to CCS.

D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS)

(A summary and detail of the number of beneficiaries assisted monthly. The monthly auto assignment rate including MCO information and island of residence. The number of requests to change plans, the outcome of the request, and the monthly disenrollment requests both granted and declined over monthly MCO enrollment.)

Long Term Services and Supports (LTSS) enrollment reported by the health plans is as follows.

LTSS Enrollment [Data as of 5/21/19 2:36 pm]

Health Plan	Jan 2019	Feb 2019	Mar 2019
Aloha Care	593	488	518
HMSA	747	725	705
Kaiser	232	255	243
Ohana	3136	3081	2968
United Healthcare	2318	2226	2300
Total	**7026**	**6775**	**6734**

Plan-to-plan change requests and results, specifically for LTSS members, are not tracked. The QI program includes LTSS services amongst its benefits.

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

Member Choice of Health Plan Exercised

Number of Members	Jan 2019 – Mar 2019
Individuals who chose a health plan when they became eligible	**634**
Individuals who were auto-assigned when they became eligible	**6,480**
Individuals who changed their health plan after being auto-assigned	**2,496**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**94**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**9**

During this reporting period, 634 individuals chose their health plan when they became eligible, 2,496 changed their health plan after being auto-assigned. Also, 8,438 individuals had an initial enrollment which fell within this reporting period.

In addition, 9 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 2019 2nd quarter, MQD received and addressed the following number of members complaints.

Month	# of Member Complaints/Grievances
January 2019	8
February 2019	7
March 2019	9
Total	**24**

B. Appeals

The hearing held in February (reported in 1st quarter) was decided in DHS' favor.

For the 2nd quarter, there were six (6) member appeals. Three (3) of the appeals were withdrawn or dismissed. Two (2) of the hearings were decided in DHS' favor. One (1) is pending a hearing that is scheduled near the end of May.

The types of appeals were: (2) Long Term Services and Supports (LTSS), (2) ABA, (1) Medication, and (1) DME.

Member Appeals	#			
	Jan 2019	Feb 2019	Mar 2019	TOTAL
Submitted	1	3	2	6
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	0	0	3	3
Dismiss as untimely filing	0	0	0	0
Member withdrew hearing request	0	0	0	0
Resolution in DHS favor	0	2	0	2
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	0	1	1

Types of Member Appeals	#			
	Jan 2019	Feb 2019	Mar 2019	TOTAL
Medical	0	0	0	0
LTSS	1	1	0	2
Van modification	0	0	0	0
ABA	0	0	2	2
DME	0	1	0	1
Reimbursement	0	0	0	0
Medication	0	1	0	1

X. Demonstration Evaluation and Interim Findings

(Evaluation of the demonstration, capturing the state's progress on evaluation design and planning, and ongoing activities of the demonstration. Include key milestones accomplished, challenges encountered, and how they were addressed. Also include, when available and where applicable: interim findings; status of contracts with independent evaluator(s); status of Institutional Review Board approval; and status of study participant recruitment. For example, whether the state has contracted with an independent evaluator, primary data collection activities the state planned for, analyses conducted, and highlights of initial findings.)

After an extensive, collaborative approach between CMS and MQD between 2014 and 2018, CMS approved the evaluation design on February 23, 2018. MQD completed a draft interim evaluation on June 29, 2018 and shared it with CMS for comments. CMS returned comments in July 2018. MQD adopted those comments and finalized the interim evaluation in late July 2018. The final interim evaluation was submitted to CMS alongside our Section 1115 renewal on July, 27 2018.

As part of the negotiation process for the 1115 renewal, MQD and CMS have been working on new 1115 evaluation requirements. Those requirements will be finalized when the upcoming Special Terms and Conditions are finalized.

XI. Quality Assurance and Monitoring Activity

(Identify any quality assurance/monitoring activity in the quarter.)

Quality Activities During The Quarter January to March 2019

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)

January:

- Module 4 and 5 refresher training done on 01/08/19.
- PIP technical assistance provided to two health plans.

February:

- Provided PIP technical assistance to remaining three health plans.
- Received the Module 4 and 5 submissions for validation on 02/15/19.

March:

- Worked on validating Modules 4 and 5.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

January:

- Conducted survey sample frame validation for the Child CAHPS survey. All sample frames were locked in a timely manner and made available to MQD and the survey team. The Healthcare Organization Questionnaire was updated for all five health plans.
- Received completed Roadmaps from the health plans by 01/31/19.
- Conducted hybrid measure abstraction tool reviews with health plans' vendors for Medical Record Review Validation.

February:

- Confirmed onsite audit dates for all health plans from 04/09/19 to 04/16/19.
- The auditors sent out their Convenience Sample letters to all plans by 02/20/19.
- Roadmap sections 4.3 and 4.5 have been approved for all plans.
- Pre-onsite Kick-off calls conducted with three health plans.
- Initiated source code review for non-HEDIS measures.

March:

- Finalized approval of all supplemental data (standard and nonstandard) for four health plans.
- Conducted pre-onsite kick-off calls with two health plans on 03/01/19 and on 03/08/19.
- Approved source code for non-HEDIS performance measures for one health plan on 03/29/19.

3. Compliance Monitoring

January:

- Participated in pre-discussion meeting for one health plan with the MQD to align objectives and expectations on 01/3/19.
- Participated in a conference call with one health plan and the MQD to review required actions necessary to resolve the outstanding corrective action plan (CAP) items on 01/09/19.
- Submitted updated another health plan's CAP to the MQD to review. Received approval from the MQD to close their final CAP item on 01/11/19.
- Posted finalized Compliance Monitoring Review tools to the FTP and notified the health plans on 01/04/19.
- Conducted the 2019 compliance review technical assistance webinar for the health plans on 01/14/19.

February:

- Received and reviewed KFHP's updated and executed MOU with HPMG. Findings and recommendation to close final CAP item sent to MQD 02/28/19.

- Received health plan desk review documents for 2019 compliance review on 02/1/19.
- Began pre-onsite desk review of health plan documents.
- Posted onsite file review samples to FTP and notified health plans.

March:

- Closed last health plan's final 2017 CAP item on 03/08/19.
- Completed pre-onsite desk review of health plan documents.
- Completed on-site compliance reviews of all 5 health plans and CCS.

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

January:

- Received approval on updated timeline from the MQD on 01/24/19.
- Received updated sample frame files from the MQD on 01/28/19.
- Received confirmation from the MQD that there are no concerns with the frequency findings of the CHIP sample frame file on 01/28/19.

February:

- Received the sample frame files for deduplication from two QI health plans on 02/06/19.
- Submitted the sample frame files to subcontractor on 02/06/19.
- Submitted finalized survey mail materials for the Child Medicaid QI health plans and CHIP population on 02/19/19.
- Ran survey samples through the U.S. Postal Service's National Change of Address (NCOA) system on 02/20/19.
- Printed and produced survey packets on 02/25/19.
- Mailed first questionnaires and cover letters to members on 02/26/19.

March:

- Mailed first postcard reminders to non-respondents on 03/05/19.
- Mailed second questionnaires and cover letters to non-respondents on 03/28/19.
- Submitted weekly disposition reports to the MQD.

5. Provider Survey

January:

- Incorporated analysis into Draft Provider Survey Report on 01/08/19.
- Performed internal review and validation of Draft Provider Survey Report on 01/18/19.
- Submitted Draft Provider Survey Report to the MQD for review on 01/22/19.

February:

- Received approval from the MQD on Draft Provider Survey Report on 02/01/19.
- Submitted Final Provider Survey Report to the MQD electronically on 02/06/19.
- Shipped eight (8) hard copies of Final Provider Survey Report and one (1) hard copy of Crosstabulations to the MQD on 02/12/19.

March:

- No activity as 2018 Provider Survey has closed and report was finalized.

6. Annual Technical Report

January:

- Continued drafting 2018 EQR Technical Report sections; initiate integration of Provider Survey results.

February:

- Continued drafting 2018 EQR Technical Report sections; initiate integration of Provider Survey results.

March:

- Continued drafting 2018 EQR Technical Report sections; initiate integration of Provider Survey results.
- Submitted initial draft of 2018 EQR Technical Report to the MQD to review.
- Received feedback from the MQD on Sections 1, 2, 4, and Appendix A.

7. Technical Assistance

January:

- None at this time.

February:

- None at this time.

March:

- None at this time.

XII. Quality Strategy Impacting the Demonstration

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

MQD contracted with a vendor, Myers & Stauffer, to work on updating quality strategy to align with the new QI RFP and HOPE Initiatives. MQD plans to begin earnest discussions with Myers & Stauffer on the quality strategy update in the FFY 2019 4th quarter.

XIII. Other

Final Rules

During the reporting period, MQD received "pre-approval" of QI RFP Supplemental Changes (SC) #11 regarding 2019 rates and scope from CMS. MQD also received "pre-approval" for CCS RFP SC#1 and EQRO RFP SC#5. MQD is working on contract execution.

Provider Management System Upgrade (PMSU)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD has moved forward with upgrading existing provider management software. A PMSU vendor was selected in FFY 2018 quarter three, and we received approval of this vendor contract in FFY 2019 quarter one. The Internal Verification & Validation (IVV) vendor was selected in FFY 2018 quarter four, to monitor the PMSU project.

In the current period, MQD continued to work with the vendor on designing PMSU and utilize our fiscal agent vendor to help with input and processing of provider enrollment re-validations.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) is working towards the implementation of Electronic Visit Verification (EVV). In the federal fiscal year (FFY) 2019 Quarter 2 (Q2), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation. Primary efforts were focused upon EVV vendor selection and approval. EVV vendor selection of Sandata was announced. Additional efforts primarily revolved around stakeholder identification activities for the statewide EVV vendor. Progress was communicated to stakeholders via several modes of communication including email, face-to-face meetings, and EVV webpage updates.

MQD's future EVV workplans include official EVV procurement award to Sandata in June – after CMS approval; continue working with the IV&V provider to ensure the Medicaid Enterprise Certification Lifecycle requirements are met as well as ensuring a successful implementation and certification of the EVV solution; and working with the EVV vendor towards an implementation date projected in the winter of 2019.

JANUARY

- MQD worked with AHCCCS in the vendor selection process narrowing the field of viable candidates. MQD recorded the current caregiver workflows ensuring a smooth transition from paper to electronic. Stakeholders involved with the current workflows were identified and contacted establishing a flow of communication.

FEBRUARY

- Collaborated with a Financial Intermediary providing an EVV project update that was posted in their February 2019 newsletter.
- The EVV vendor selection of Sandata was announced on February 26th, 2019. The announcement was posted on MQDs EVV webpage and an email announcement was sent to over 150 representatives from MCOs, Providers, Associations, Agencies, and Workers.

MARCH

- Weekly meetings established with IVV vendor SLI Government Solutions, AZ, HI, and CMS. The first EVV Vendor (Sandata) / AZ / HI meeting was held to introduce the teams, discuss the process, and the next steps.
- The Implementation Advanced Planning Document was submitted to CMS in March.
- Engaged in communication outreach with Healthcare Association of Hawaii (HAH) and HHCS agencies on March 27th discussing the EVV initiative and its projected timeline. Concerns were raised about the amount of time remaining in the year to implement IT changes that would automate the process relating to EVV. MQD is reviewing the issue and the options.

Hawaii DHS MITA SS-A Project: Med-QUEST Management Visioning and BA Planning Session

In the reporting period, MQD launched the Medicaid Information Technology Architecture (MITA) initiative to stimulate an integrated business and IT transformation across State Medicaid Enterprises. Contractor, Cognosante, was selected for this project. First meeting with all the MQD branch administrators was held on March 6, 2019 and various meeting, conference calls and webinar to follow.

The goals for this project are to have healthy families and healthy communities to achieve the triple aim of better health, better care and sustainable costs. Strategies are:

1. Invest in primary care, prevention and health promotion
2. Improve outcomes for high-need, high-cost individuals
3. Payment reform and financial alignment
4. Support community driven initiatives

Foundational building blocks include using data and analytics to drive transformation and improve care, increase workforce capacity and accountability, performance measurement and evaluation.

MQD Workshops and Other Events

Training Focus:		**Affordable Housing System Housing 101: The Basics**	
For:		**MCO Service Coordinators**	
Trainer	Betty Lou Larson	**Location**	Webinar
Length	1.5 hours	**Dates**	February 27, 2019
Attendees	Approximately 300		
Description	Overview of Supportive Housing		
Objectives/Outcomes	• Familiarity with common housing terms • Understanding the housing market and affordability • Increase familiarity with Hawaii's affordable housing system • Learn about types of housing and rental assistance		

A. Enclosures/Attachments

(An up-to-date budget neutrality worksheet must be provided as a supplement to the Quarterly Report. In addition, any items identified as pertinent by the State may be attached. Documents must be submitted by title along with a brief description in the Quarterly Report of what information the document contains.)

Attachment A: QUEST Integration Dashboard for January 2019 – March 2019

The QUEST Integration Dashboard compiles monthly data submitted by the Health Plans to MQD, regarding enrollment, network providers, call center calls, medical claims, prior authorizations, non-emergency transports, grievances, appeals, and utilization. [Data as of 5/21/19 2:36 pm]

Attachment B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 12/31/2018 is attached. The Budget Neutrality worksheet for the quarter ending 3/31/2018 will be submitted by the 5/31/2019 deadline.

B. MQD Contact(s)

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